



Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992

2023

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Please note that these guidelines are not intended as a substitute for informed legal opinion. Any concerns individuals may have should be discussed with appropriate legal advisors.

These guidelines are not clinical guidelines. They are issued pursuant to section 130(1)(a) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 Act and intended to support the lawful application of the Act, which states that the Director-General of Health may from time to time issue guidelines for the purposes of the Act.

Citation: Ministry of Health. 2023. *Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

Published in April 2023 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-991075-13-0 (online)
HP 8734



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Introduction

Manatū Hauora (the Ministry of Health) has updated these guidelines, first published in 2010.

The guidelines provide best-practice alternatives to the use of seclusion and restraint in treating and caring for people who are subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). They take a significantly different approach to the previous guidelines, which had not kept pace with the research, practice, and policy in this area.

The updated guidelines are grounded in person-centred approaches, human rights and Te Tiriti o Waitangi and reflect our commitment to reducing and eventually eliminating seclusion and restraint. They aim to help shift practices towards a seclusion- and restraint-free environment, which maintains people's autonomy, dignity and mana.

Since the current Mental Health Act came into force, there have been fundamental shifts in our understanding of how restrictive practices adversely affect tāngata whaiora. Newer person-centred, safe and evidence-based models are now available.

It is now recognised that seclusion and restraint have no therapeutic benefit, and in fact can be harmful and traumatic to tāngata whaiora, their whānau and staff in mental health inpatient units.

Providers may lawfully use seclusion under the Mental Health Act. However, they should only use it as a last resort, to prevent harm in emergency situations, when they have tried other less restrictive strategies. Through application of these guidelines and alternative person-centred and culturally appropriate approaches, we expect to see the use of seclusion and restraint only rarely.

Key changes in our approach since these guidelines were first published include a growing awareness and influence of rights-based approaches and the need to give greater emphasis to our obligations under Te Tiriti o Waitangi. This was highlighted in *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*¹ and through feedback we received from people with lived experience and their families and whānau on how they experience current administration of the Act.

*Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*² supports the shift in practice that *He Ara Oranga* called for. *Kia Manawanui* is the whole-of-government strategy and plan to transform Aotearoa's approach to mental wellbeing. It aims to support people to stay well, while also ensuring access to help that works for tāngata whai ora, when and where they need it. These guidelines support the wellbeing approach in *Kia Manawanui*, which places greater emphasis on supporting people to proactively manage their recovery and wellbeing.

¹ Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction.

² Ministry of Health. 2021. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Wellington: Ministry of Health.

In addition, the updated Ngā Paerewa Health and Disability Services Standard (NZS 8143:2021) (Ngā Paerewa) came into effect in February 2022. It reflects the shift towards person-centred and whānau-centred health and disability services, in which people are empowered to make decisions about their own care and support and to achieve their goals. These guidelines align with, and will help mental health inpatient services meet, the requirements of Ngā Paerewa in relation to seclusion and restraint.

The Government has agreed to repeal and replace the Mental Health Act, as recommended by *He Ara Oranga*. This work is under way, and is guided by principles that include, among others, the need for new legislation to reflect a human rights approach, to recognise and respect Te Tiriti o Waitangi and to support people's maximum independence and inclusion in society, as well as the safety of individuals, their whānau and the community. We will review these guidelines once the new legislation has been developed.

While longer-term work to repeal and replace the Mental Health Act progresses, we do not need to wait to improve practice under the current Act and to enhance support for tāngata whai ora currently receiving care. Work is already underway to change practices and reduce the use of seclusion in mental health services. This is reflected, for example, in the Health Quality & Safety Commission (HQSC)'s Zero Seclusion: Safety and Dignity for All project and the Ministry's recently updated *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Guidelines to the Mental Health Act)*.³ These guidelines are another example of how we are doing this.

These guidelines represent an important step in the transition towards a future that realises pae ora:⁴ healthy futures and mental wellbeing for all. For people who receive compulsory mental health treatment, this means a system and services grounded in te ao Māori and contemporary rights-based approaches, in which seclusion and restraint are rarely or never used.

How to use these guidelines

All inpatient mental health services need to have in place local policies, procedures and clinical practices that reduce and, where possible, eliminate the use of seclusion and restraint. These need to consider the particular service setting, populations served and any other relevant local factors.

These guidelines set out our expectations of what services should consider in establishing policies and procedures on the use of seclusion and restraint, in line with Ngā Paerewa.

We consider Māori and Pacific people to be priority populations for the purposes of these guidelines, due to the inequities we know these groups experience. While data on outcomes for people with disabilities in mental health services is limited, we note

³ Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

⁴ www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures (accessed 23 March 2023)

that service providers should also give particular consideration to ensuring that services are accessible to this group of tāngata whaiora.

Implementing these guidelines within mental health services is primarily the responsibility of organisation and service leaders, including executive leaders, mental health service and clinical leaders, and Directors of Area Mental Health Services (DAMHSs). However, everyone who has a role in providing treatment, care or support for people who are subject to the Mental Health Act should do so in alignment with these guidelines.

Services should ensure an adequate level and mix of staffing to implement these guidelines. This includes kaimahi Māori and staff with a peer or lived experience role.

Services must also ensure that all staff are appropriately skilled and trained in the approaches outlined in these guidelines, including:

- working with tāngata whaiora Māori
- cultural safety and understanding racism and bias
- a human rights approach, including Te Pou's Mental Health Act e-learning modules⁵
- trauma-informed approaches
- best-practice restraint minimisation (through training such as the Safe Practice Effective Communication or equivalent training programme)
- sensory modulation.

To allow time for mental health services to make necessary changes to their policies and procedures, these guidelines will come into effect from 1 July 2023. However, services should make every effort to give effect to these guidelines as soon as possible.

Some notes on terminology

Use of the term 'patient'

Manatū Hauora acknowledges that many people in Aotearoa New Zealand disagree with use of the terms 'patient' and 'proposed patient'. This view is understandable: such terms can reflect a stigmatisation of people who experience mental distress. Such people are at risk of being managed through medical treatment, rather than being treated as individuals with choices and autonomy.

These guidelines use the word 'patient' when referring to a specific part of the Mental Health Act in which 'patient' and 'proposed patient' have a specific legal meaning and confer certain rights and responsibilities under the Act. These guidelines also use the terms 'person with lived experience' (which Ngā Paerewa uses) and 'tāngata whaiora' to refer to people who experience mental distress.

⁵ www.tepou.co.nz/initiatives/mha/mental-health-act-e-learning (accessed 29 March 2023).

Use of the term 'seclusion'

Manatū Hauora acknowledges that some people believe that 'solitary confinement' is a more appropriate term to use than 'seclusion'. These guidelines are issued under the Mental Health Act, which uses the term seclusion. In addition, Ngā Paerewa provides a definition of seclusion and sets criteria for the use of seclusion in the health and disability sector. Therefore, these guidelines also use the term 'seclusion' for the sake of consistency.

Use of the term 'lived experience'

Manatū Hauora acknowledges that there are different preferences for referring to people's experience of mental distress, including 'mental health condition' and 'crisis'. For the purpose of these guidelines, and after consulting with individuals with lived experience, we have decided to use the terms 'mental distress' or 'period of acute mental distress'.

Part One: Purpose and context of the guidelines

1 Purpose

The purpose of these guidelines is:

- to support the safe reduction and elimination of seclusion and restraint for people under the Mental Health Act, and
- when it has not been possible to avoid the use of seclusion and restraint, to identify best-practice methods for use in mental health inpatient units (including forensic mental health inpatient units) that align with the specifications set out in Ngā Paerewa.

'Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained'

Ngā Paerewa, 'Here Taratahi Restraint and Seclusion', Outcome 6

This document should be read within the context of other relevant legislation, regulations and guidelines, including:

- the Care of Children Act 2004
- the Declaration on the Rights of Indigenous Peoples
- *Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services*⁶
- *Guidelines to the Mental Health Act and Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*⁷
- the Code of Health and Disability Services Consumers' Rights
- the United Nations Convention on the Rights of Persons with Disabilities
- United Nations Declaration on the Rights of Indigenous Peoples
- the HQSC's Code of expectations for health entities' engagement with consumers and whānau
- the Health and Safety at Work Act 2015

⁶ Ministry of Health. 2022. *Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services*. Wellington: Ministry of Health.

⁷ Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health; Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

- the Health and Safety at Work (General Risk and Workplace Management) Regulations 2016
- the Mental Health Act
- Ngā Paerewa
- the Oranga Tamariki Act 1989
- the Pae Ora (Healthy Futures) Act 2022
- Te Pou's Six Core Strategies© for reducing seclusion and restraint⁸
- *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Service*⁹
- Te Tiriti o Waitangi
- the HQSC's Zero Seclusion: Safety and Dignity for All resources: change package, cultural kete and clinical bundle.¹⁰

Note that these guidelines do not apply to the application of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. There are separate guidelines for the use of seclusion under that Act.

⁸ www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/the-six-core-strategies-service-review-tool (accessed 29 March 2023).

⁹ Ministry of Health. 2022. *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services*. Wellington: Ministry of Health.

¹⁰ www.hqsc.govt.nz/assets/Our-work/Mental-health-and-addiction/Resources/Zero-seclusion-change-package/Zero-seclusion-change-package-final.pdf (accessed 29 March 2023).

2 Context

2.1 The commitment to reducing and eliminating seclusion and restraint

Manatū Hauora supports the reduction and elimination of seclusion and restraint in mental health services.¹¹

We recognise that seclusion and restraint have no therapeutic benefit and can be harmful both for tāngata whaiora and staff.^{12,13} The types of harm caused to tāngata whaiora include psychological trauma (for example, through re-triggering existing traumas), physical injury including death, cultural harm¹⁴ and damage to therapeutic relationships.^{15,16} Seclusion and restraint are damaging to autonomy, mana and dignity.¹⁷ As Māori and Pacific people are more likely to experience seclusion and restraint,¹⁸ they bear a disproportionate amount of the harm New Zealanders experience from seclusion and restraint. The risk of physical injury during restraint appears to be higher for children and adolescents and for people with physical health challenges.¹⁹

Seclusion and restraint have no therapeutic benefit and can be harmful both for people experiencing mental distress and for staff.

¹¹ Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health.

¹² Te Pou o te Whakaaro Nui. 2008. *Reducing and Eliminating Seclusion in Mental Health Inpatient Services: An Evidence Review for the Health Quality & Safety Commission New Zealand*. Auckland: Te Pou o te Whakaaro Nui.

¹³ Bigwood S. 2008. 'It's part of the job, but it spoils the job': A phenomenological study of physical restraint. *International Journal of Mental Health Nursing* 17(3): 215–22.

¹⁴ 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': see royalsociety.org.nz/assets/Uploads/Code-of-Prof-Stds-and-Ethics-Revision-2.pdf (accessed 29 March 2023).

¹⁵ Brophy, LM, Roper CE, Hamilton BE, et al. 2016. Consumers and their supporters' perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups. *International Journal of Mental Health Systems* 10(1): 1–10.

¹⁶ Kinner SA, Harvey C, Hamilton B, et al. 2017. Attitudes towards seclusion and restraint in mental health settings: findings from a large, community-based survey of consumers, carers and mental health professionals. *Epidemiology and Psychiatric Sciences* 26(5): 535–44.

¹⁷ Barnett R, Stirling C, Pandyan AD. 2012. A review of the scientific literature related to the adverse impact of physical restraint: gaining a clearer understanding of the physiological factors involved in cases of restraint-related death. *Medicine, Science and the Law* 52(3): 137–42.

¹⁸ Ministry of Health. 2022. *Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2020 to 30 June 2021*. Wellington: Ministry of Health.

¹⁹ Mohr WK, Petti TA, Mohr BD. 2003. Adverse Effects Associated with Physical Restraint. *Canadian Journal of Psychiatry* 48(5): 330–7.

The use of seclusion and restraint can also cause distress or harm to other tāngata whaiora and staff who witness it.

Experience from overseas and locally suggests it is possible to stop using seclusion and minimise restraint in mental health services. Evidence from Aotearoa New Zealand also suggests the key factors in supporting the reduction of seclusion and restraint are related to organisational culture, including service delivery models and practice approaches, rather than factors intrinsic to tāngata whaiora. This means concerted efforts from services and practitioners can truly make change.^{20,21}

2.2 Upholding Te Tiriti o Waitangi and people's rights

2.2.1 Te Tiriti o Waitangi

Manatū Hauora and public mental health service providers have a responsibility to contribute to the Crown meeting its obligations under Te Tiriti o Waitangi. The principles of Te Tiriti provide the framework for meeting our obligations under Te Tiriti in our day-to-day work.

The Pae Ora (Healthy Futures) Act 2022 requires the health sector, in providing for the Crown's intention to give effect to the principles of Te Tiriti, to be guided by the health sector principles (section 6(a)), which include equity of access and outcomes for Māori (section 7(1)(a)), engaging with Māori on service delivery to improve hauora Māori outcomes (section 7(1)(b)) and provision of quality services to Māori (section 7(1)(d)).

The following principles will help services apply these guidelines in line with Te Tiriti.²²

- **Tino rangatiratanga:** The guarantee of tino rangatiratanga provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity:** The principle of equity requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection:** The principle of active protection requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents, and its Treaty partner are well informed on the extent and nature of both Māori health outcomes, and efforts to achieve Māori health equity.
- **Options:** The principle of options requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally

²⁰ www.hqsc.govt.nz/resources/resource-library/zero-seclusion-case-studies-how-dhbs-are-successfully-reducing-the-use-of-seclusion/ (accessed 28 March 2023).

²¹ Te Pou provides a range of resources and evidence on least restrictive practice at www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint (accessed 28 March 2023).

²² www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi (accessed 28 March 2023).

appropriate way that recognises and supports the expression of hauora Māori models of care.

- **Partnership:** The principle of partnership requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services.

All staff within mental health services need a good understanding of Te Tiriti. Services should support staff to develop their cultural competency and cultural safety through training. The *Guidelines to the Mental Health Act*²³ describe how Te Tiriti and its principles relate to the application of the Mental Health Act and outlines how clinicians and services can align their practices with these principles.

2.2.2 Achieving equity

In Aotearoa New Zealand, people experience differences in health outcomes that are not only avoidable, but also unfair and unjust. To prioritise equity is to recognise that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.²⁴ Additionally, tāngata whaiora who are Māori and Pacific peoples experience inequitable differences in treatment and care. We recognise that racism and the effects of colonisation contribute to these inequitable outcomes.^{25,26}

‘The Treaty principles of equity and active protection [...] require the Crown to make every reasonable effort to eliminate barriers to services that may contribute to inequitable health outcomes’.
Hauora: Report on stage one of the health services and outcomes kaupapa inquiry

Māori and Pacific peoples are significantly more likely to experience seclusion and restraint than people of other ethnicities.²⁷ These inequities are unacceptable, and mental health services must address them with urgency.

The *Guidelines to the Mental Health Act* reiterate Right 1(3) of the Code of Health and Disability Services Consumers' Rights, stating that every person accessing services 'has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.'

In relation to restraint, the *Guidelines to the Mental Health Act* state that services must receive training and implement operational policies and strategies in culturally

²³ Ministry of Health. 2022. [Guidelines to the Mental Health \(Compulsory Assessment and Treatment\) Act 1992](#). Wellington: Ministry of Health.

²⁴ The Ministry's definition of equity was signed off by Director-General of Health Dr Ashley Bloomfield, in March 2019. See www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity (accessed 22 March 2023).

²⁵ www.health.govt.nz/about-ministry/what-we-do/combating-racism-health-system (accessed 28 March 2023).

²⁶ www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha (accessed 28 March 2023).

²⁷ Ministry of Health. 2021. *Office of the Director of Mental Health and Addiction Services Annual Report 2018 and 2019*. Wellington: Ministry of Health.

competent best-practice approaches that positively and authentically address the high rates of restraint that Māori and Pacific tāngata whaiora experience.

Tikanga-informed best practice is an important part of cultural competence and achieving equity. The Waitangi Tribunal's report *Hauora: Report on stage one of the health services and outcomes kaupapa inquiry* explains the importance of culturally appropriate care, stating:

The Crown has a Treaty obligation to ensure that health services are culturally appropriate. This is important because [...] providing care in a way that respects and understands Māori sociocultural paradigms is a care access issue, and impacts on the quality of health care received or, indeed, dictates whether care is received at all. [...] As such, ensuring care is culturally appropriate ensures equitable access to care.²⁸

2.2.3 Taking a rights-based approach

A rights-based approach to mental health promotes and protects human rights in policy and in services, including a person's right to autonomy, dignity, self-determination and tino rangatiratanga. A rights-based approach to mental health means that a person remains central to all decisions that affect them, including decisions about their treatment and care.

Compulsory treatment does not mean that people lose their human rights. Rather, decisions about compulsory treatment require clinicians to balance an individual's rights against the need for coercive interventions permitted under the Mental Health Act. To avoid unnecessarily infringing on people's human rights, services should provide compulsory treatment in a manner that is consistent with the New Zealand Bill of Rights Act 1990, the Health and Disability Code of Patient Rights and Te Tiriti principles to the greatest extent possible, and in the least restrictive way. The human rights mechanisms discussed below also set out important rights and protections for people receiving compulsory mental health treatment.

The Human Rights Commission has released guidance to help health professionals understand the human rights to health care and health protection: the *Guide to the rights to healthcare and health protection in Aotearoa New Zealand* is available on its website.²⁹

2.2.4 International human rights agreements

Aotearoa New Zealand has obligations under international human rights agreements. The most relevant to the rights of people receiving compulsory mental health treatment include:

- the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

²⁸ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the health services and outcomes kaupapa inquiry*. WAI 2575. Wellington: Waitangi Tribunal, p.155.

²⁹ tikatangata.org.nz/news/new-guide-to-help-health-professionals-deliver-rights-to-healthcare-and-health-protection (accessed 28 March 2023).

- the United Nations Convention on the Rights of Persons with Disabilities
- the United Nations Convention on the Rights of the Child
- the United Nations Declaration on the Rights of Indigenous Peoples
- the International Convention on the Elimination of all forms of Racial Discrimination.

Information about these human rights agreements and how they relate to the Mental Health Act is provided in *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*,³⁰ a guidance document issued by Manatū Hauora.

2.2.5 Providing a safe environment for all

Services are obliged to protect the people in their care from harm in an inpatient environment. They are also obliged to provide a safe environment for the staff responsible for caring for those people.

2.2.6 Health and safety at work

The Health and Safety at Work Act 2015 and related regulations require that workers and others are given the highest level of protection from workplace health and safety risks, so far as is reasonably practicable. This includes risks to both physical and mental health.

Services are required to ensure that the workplace meets required health and safety standards, and provide a combination of relational, environmental, and procedural security. For example, services are required to ensure agreed minimum staffing ratios in each workplace. They should implement agreements to increase staffing levels when there are early warning signs of acuity increasing to a point that will compromise the safety of staff and people using the service.

2.2.7 New Zealand Bill of Rights Act and Health and Disability Code of Patient Rights

The New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993 give expression to New Zealand's international human rights obligations. Under section 19 of the New Zealand Bill of Rights, everyone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993, including freedom from discrimination on the grounds of ethnicity. Under section 23(5) of the New Zealand Bill of Rights Act, everyone deprived of liberty shall be treated with humanity and with respect for the dignity of the person.

The Code of Rights is New Zealand's mechanism for protecting people's rights in relation to health and disability care.

³⁰ Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

Rights set out in the Code of Rights apply alongside the Mental Health Act, except where a legal obligation, duty or authorised act expressly overrides them. It is important to note that being subject to the Mental Health Act does not override someone's rights under the Code entirely, but only as much as is necessary for the express exclusion.

A person's rights under the Code of Rights should be seen in their entirety, rather than in isolation. For example, if someone's right to consent to treatment is overridden to mandate treatment, then their other rights become even more essential; for example, the right to effective communication and to care of an appropriate standard which meets their needs.

When a person who is subject to a compulsory mental health assessment and treatment has their right to refuse treatment temporarily overridden, they still have the right to express their preferences in relation to that treatment and have their preferences taken into consideration. More guidance on how to think about and apply human rights, recovery approaches and supported decision-making when implementing the Mental Health Act is provided in *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*.³¹

2.2.8 District inspectors

District inspectors are lawyers appointed under the Mental Health Act to uphold the rights of people who are subject to the Mental Health Act and to receive complaints about breaches of rights specified in Part 6 of that Act. District inspectors have a key role in advising tāngata whaiora of their rights during the assessment process and when the responsible clinician requests a compulsory treatment order. People have the right to make a complaint to a district inspector if they consider that their rights under the Act have been breached during a seclusion or restraint event. Where district inspector considers that a complaint has substance, he or she must report the breach to the DAMHS and may make recommendations for action. The DAMHS must take all steps to remedy the matter.

2.2.9 He Ara Oranga

*He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*³² set a direction for mental health and addiction services based on equity and wellbeing, recognising the importance of social determinants, and providing readily accessible support for all.

He Ara Oranga recommends new mental health legislation 'to reflect a human rights approach, promote supported decision-making and align with a recovery and wellbeing model, and minimise compulsory or coercive treatment'.³³ The Government has accepted the recommendation to repeal and replace the Mental Health Act, and this work is under way.

³¹ Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

³² Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction.

³³ *He Ara Oranga*, p. 14.

Submitters to *He Ara Oranga* described ‘the trauma of compulsory detention and treatment, the loss of their right to participate in decisions about their treatment and recovery, the adverse impacts of forced medication, and the harm and powerlessness they experienced through practices of seclusion and restraint and prolonged use of the Mental Health Act’.³⁴

2.2.10 Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing

*Kia Manawanui*³⁵ is the long-term pathway for transforming New Zealand’s approach to mental wellbeing so that people are supported to stay well, and have access to help that works for them, when and where they need it. It supports the agenda set by *He Ara Oranga* and seeks to both build on the strengths of our existing systems and services and to create new and different approaches to supporting mental wellbeing taking a whole-of-government approach.

2.3 Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)

Ngā Paerewa sets out the minimum requirements for providers of health and disability services.³⁶

Ngā Paerewa reflects the shift towards person-centred and whānau-centred health and disability services. It aims to empower people to make decisions about their own care and support and to achieve their goals, with a stronger focus on outcomes for people receiving support.

The principles of Te Tiriti underpin Ngā Paerewa and are reflected in the outcome statements and criteria.

Outcome 6 ‘Here Taratahi Restraint and Seclusion’ in Ngā Paerewa states ‘Services shall aim for a restraint and seclusion free environment, in which people’s dignity and mana are maintained.’

There are 4 sets of criteria under Outcome 6: restraint processes (section 6.1), safe restraint (section 6.2), quality review (section 6.3) and seclusion (section 6.4). These criteria include a greater emphasis on governance, leadership and monitoring, and

³⁴ *He Ara Oranga*, p. 189.

³⁵ Ministry of Health. 2021. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Wellington: Ministry of Health.

³⁶ Ngā Paerewa came into effect on 28 February 2022, and replaced the Health and Disability Services Standards (NZS 8134:2008).

debriefing following a seclusion or restraint event, compared with the previous set of health and disability standards.

The intention of these guidelines is to help inpatient mental health services meet the requirements of Ngā Paerewa set out in Outcome 6. Ngā Paerewa 'should be interpreted in a manner that is consistent with Te Tiriti obligations, people's rights and service provider obligations under the Code of Health and Disability Services Consumers' Rights' (Ngā Paerewa, 0.1.2 Application).

The outcome statements of Ngā Paerewa section 6 are as follows.

The people:	Te Tiriti:	Service providers:
<ul style="list-style-type: none"> • I trust the service provider is committed to improving policies, systems and processes to ensure I am free from restrictions. • I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. • I feel safe to share my experiences of restraint so they can influence least restrictive practice. • I trust that service providers do all that they can to enable health care and support workers to explore all other options so that I am not secluded. 	<ul style="list-style-type: none"> • Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. • Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. • Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions. • Service providers take a person- and whānau-centred approach, to ensure there is no seclusion 	<ul style="list-style-type: none"> • We demonstrate the rationale for the use of restraint in the context of aiming for elimination. • We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort. • We maintain or are working towards a restraint-free environment by collecting, monitoring and reviewing data and implementing improvement activities. • We no longer consider seclusion a therapeutic intervention, and it only occurs when our environment is not conducive to the elimination of seclusion.

2.4 Definitions of restraint and seclusion

2.4.1 Restraint

Ngā Paerewa defines restraint as: 'The use of any intervention by a service provider that limits a person's normal freedom of movement. Where restraint is consented to by a third party, it is always restraint' (Ngā Paerewa, section 0.3).

For the purposes of these guidelines, the following definitions of restraint apply.³⁷

- **Personal restraint**³⁸ is where a service provider uses their own body to intentionally limit a person's movement.
- **Physical/mechanical restraint**³⁹ is where a service provider uses equipment, devices or furniture that limits a person's normal freedom of movement.
- **Environmental restraint** is where a service provider intentionally restricts a person's normal access to their environment: for example, where a person's normal access to their environment is intentionally restricted by locking or blocking doors.

2.4.2 Seclusion

Ngā Paerewa defines seclusion as 'a type of restraint where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit' (Ngā Paerewa, 0.3).

Section 71 of the Mental Health Act relates to seclusion, and provides that every patient is entitled to the company of others, except where, and for as long as, seclusion is necessary for the care or treatment of the patient, or the protection of other patients.

For the purposes of these guidelines, seclusion is viewed as the most restrictive form of environmental restraint under the Mental Health Act.

While section 71 of the Mental Health Act does not explicitly say so, in practice seclusion is used to manage the safety of tāngata whaiora and staff and protect them from harm. See section 2.2.6 above.

2.4.3 Sedative medication

Prescribed medications offer a range of beneficial or therapeutic effects.

The prescribing of sedative medications is a matter of clinical decision-making and is outside the scope of these guidelines. However, we recognise that the use of sedation to

³⁷ These definitions have been adapted from the (now superseded) Health and Disability Services Standards (NZS 8134:2008).

³⁸ In other jurisdictions, personal restraint is called 'physical restraint'.

³⁹ In other jurisdictions, physical restraint is called 'mechanical restraint'.

control or manage behaviour is a very significant intervention, which has potentially serious consequences for the person being sedated, and potential effects on staff and whānau. The following information aims to assist services to ensure that medication is used safely and appropriately.

Subsection 3.4 of Ngā Paerewa sets out the criteria for the prescribing of medication. Manatū Hauora gives the sector the following guidance on compliance with Ngā Paerewa criterion 3.4.2.

Service providers prescribe and use all medications for valid therapeutic indications. They never use medications to force compliance or render a person incapable of resistance; use of medications in this way could be classed as chemical restraint and is in breach of this standard.⁴⁰

In 2019, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) endorsed a 'Guideline for safe care for patients sedated in health care facilities for acute behavioural disturbance'.⁴¹ The document sets the minimum safety standards required in caring for people where sedation is used to control behaviour that is 'judged to have the potential to result in significant harm to the individual themselves, other individuals or property.' The guideline notes at paragraph 6.1 that the 'primary goal of drug administration for [acute behavioural disturbance] is not specifically to induce sedation but rather to safely manage and modify the disturbed behaviour.'

Section 66 of the Mental Health Act provides that every patient is entitled to medical treatment and other health care appropriate to their condition. After the compulsory assessment period and the first month of compulsory treatment, further treatment cannot be given without a person's consent or, if they do not or cannot consent, without a supportive second opinion from a psychiatrist who has been approved by the Mental Health Review Tribunal to provide such opinions under section 59 of the Mental Health Act.

If a person who has received treatment under the Mental Health Act believes that any medication, including sedative medication, has been prescribed to them in a way that is not therapeutic, they may make a complaint to a district inspector or the Health and Disability Commissioner. It is important that providers support people, especially children or young people, to make a complaint.

⁴⁰ www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standard/resources-nga-paerewa-health-and-disability-services-standard/sector-guidance-nga-paerewa-health-and-disability-services-standard-nzs-81342021/part-3 (accessed 29 March 2023).

⁴¹ www.anzca.edu.au/getattachment/eccd42fd-1463-4964-9059-d49396d10472/PS63-Guideline-for-safe-care-for-patients-sedated-in-health-care-facilities-for-acute-behavioural-disturbance (accessed 31 March 2023).

2.5 Leadership and governance

Leadership and governance at the executive level are essential for services to achieve a seclusion and restraint-free environment. Leadership is one of the Six Core Strategies[©] for reducing seclusion and restraint. Effective leadership is needed to shift culture and attitudes from risk-averse practice to supportive and culturally safe practice. In line with Te Tiriti, leadership and governance need to include Māori representation.

Working towards minimising and, where possible, eliminating the use of seclusion and restraint requires commitment and leadership to changing practices and continuing investment in the delivery of high-quality care.

Royal Australian and New Zealand College of Psychiatrists Position Statement 61. August 2021.

Ngā Paerewa includes criteria for governance and executive leadership, stating that:

- governance bodies shall demonstrate commitment towards eliminating restraint (Ngā Paerewa criterion 6.1.1)
- services providers shall demonstrate a commitment to ensuring that the voice of people with lived experience, Māori and whānau is evident in restraint oversight groups (Ngā Paerewa criterion 6.1.2)
- there shall be an executive leader who is responsible for ensuring the commitment to restraint minimisation and elimination is implemented and maintained (Ngā Paerewa criterion 6.1.3).

Additionally, the *Guidelines to the Mental Health Act*⁴² state that services should:

- address systemic issues that drive the use of restraint. These include organisational skills and experience, workplace culture and workforce practices
- address the environmental issues that drive the use of restraint. These may include building design, noise levels, line of sight and other issues.

⁴² See section 14.7.3 of the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*.

Part Two: Preventing seclusion and restraint

3 Initiatives to reduce and eliminate seclusion and restraint

This section sets out the evidence-based initiatives and resources that have been developed by, and for, mental health and addiction service providers to support least restrictive practice and the reduction and elimination of seclusion and restraint in partnership with Māori, whānau and people with lived experience of mental distress. This is not an exhaustive list but sets out key actions to reduce and eliminate seclusion and restraint.

People with lived experience 'trust the service provider is committed to improving policies, systems and processes to ensure [they are] free from restrictions.'

Ngā Paerewa outcome statement, subsection 6.1

3.1 Six Core Strategies

The Six Core Strategies© are evidence-informed, effective approaches to reduce seclusion and restraint events for both adults and young people.^{43,44} Te Pou has adapted the Six Core Strategies© and supports services to implement them within an Aotearoa New Zealand context.

The Six Core Strategies© service review tool (2020)⁴⁵ aims to support leaders and managers in implementing the Six Core Strategies© in mental health services. The tool is designed to help services to regularly review their progress in shifting towards least restrictive practices through identifying key priorities and supporting ongoing quality improvement and systems change.

⁴³ This whole-of-system approach was originally developed in the United States by the National Association of State Mental Health Program Directors Medical Directors Council.

⁴⁴ Azeem M, Aujla A, Rammerth M, et al. 2017. Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing* 24(1): 11–15

⁴⁵ Te Pou o te Whakaaro Nui. 2020. *Six Core Strategies© service review tool: New Zealand adaption* (2nd edition). Auckland: Te Pou o te Whakaaro Nui.

The Six Core Strategies© resources are available on the Te Pou website.⁴⁶ The tool includes a commitment to the principles of Te Tiriti and cultural, human-rights and trauma informed approaches. The 6 core strategy areas are:

- leadership towards organisational change
- full inclusion of lived experience
- using data to inform practice
- workforce development
- use of seclusion and restraint reduction tools
- debriefing techniques.

3.2 Zero seclusion: Safety and dignity for all | Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha

The Zero Seclusion: Safety and Dignity for All project, which began in early 2019, focuses on eliminating seclusion in Aotearoa New Zealand. The project is part of the HQSC's wider mental health and addiction quality improvement programme, funded by Te Whatu Ora – Health New Zealand. All inpatient mental health services are part of the project.

The Zero Seclusion project aims to improve the experience of care for tāngata whaiora by further reducing seclusion rates in all mental health units, with a goal of elimination. The HQSC supports mental health services to find other ways to help people in distress, as alternatives to seclusion.

The project uses quality improvement methodology to develop and test what works best for the people and staff of a particular service. It has produced a range of evidence-based resources to support services to reduce and eliminate seclusion, available on the HQSC's website.⁴⁷ These include:

- a change package which comprises a cultural kete and clinical bundle, based on practice evidence of what has been shown to work well
- case studies showing how mental health inpatient services have successfully further reduced their use of seclusion; some have achieved zero seclusion for periods of time
- pono consumer and whānau video narratives.⁴⁸

⁴⁶ www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/the-six-core-strategies-service-review-tool (accessed 29 March 2023).

⁴⁷ www.hqsc.govt.nz/our-work/mental-health-and-addiction-quality-improvement/projects/zero-seclusion-safety-and-dignity-for-all/ (accessed 29 March 2023).

⁴⁸ www.hqsc.govt.nz/news/consumers-experience-of-seclusion/ (accessed 29 March 2023).

3.3 Safe Practice Effective Communication

Manatū Hauora expects services to provide regular and ongoing training of staff authorised to use seclusion and restraint. It is not acceptable for untrained staff, or staff whose training is out of date, to be involved in the seclusion and restraint of tāngata whaiora.

Safe Practice Effective Communication (SPEC) is a national training course that supports best and least restrictive practice in mental health inpatient units. The course includes communication, de-escalation, collaborative ways of working, training in restraint minimisation, and the teaching of personal restraint and breakaway techniques. The principles of SPEC are person-centred, least restrictive and trauma-informed, and are underpinned by the principles of Te Tiriti.⁴⁹

The *Guidelines to the Mental Health Act* endorse current SPEC training principles,⁵⁰ to optimise the physical safety of tāngata whaiora being restrained. The training principles do not include flexion-based (painful) techniques and avoid, wherever possible, the use of prone positioning (lying the person face down) due to the increased risk of injury or death.⁵¹ Such techniques also degrade the person's mana and dignity.

The SPEC training includes a requirement to demonstrate responsiveness to Māori and Pacific people; for example, by emphasising the importance of incorporating Māori and Pacific values and models of health into practice when working with Māori and Pacific tāngata whaiora and their whānau/aiga.

More information about SPEC training is available on Te Pou's website.⁵²

⁴⁹ www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/safe-practice-effective-communication (accessed 29 March 2023).

⁵⁰ See section 15.7.3 of the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*.

⁵¹ Hollins L. 2017. The NICE 10 minute physical restraint rule: a discussion of the relative risks. *Journal of Psychiatric and Mental Health Nursing* 24(9–10): 719–26.

⁵² www.tepou.co.nz (accessed 29 March 2023).

4 Person-centred approaches to preventing seclusion and restraint

This section presents methods of working with people in a period of acute mental distress that have been shown to be effective at minimising the use of seclusion and restraint. Manatū Hauora expects services to already be using these approaches as part of their models of care.

Services need to demonstrate that they are routinely using these approaches and show progress towards implementing any that are not currently part of their model of care.

Ngā Paerewa defines 'person-centred' as 'focusing care on the needs of the individual; ensuring that people's preferences, needs, and values guide clinical decisions or disability support; and providing care that is respectful of and responsive to them.'⁵³ A person-centred approach requires staff to work in a compassionate, relational, and supportive manner to help a person feel safe and supported.

The following paragraphs describe some important person-centred approaches that Manatū Hauora expects services to incorporate in their models of care, and indicates where to find more information about them.

4.1 Working in partnership with Māori

Further to section 2.2 of these guidelines, we expect services to work in partnership with tāngata whaiora Māori, their whānau and their local iwi and hapū. This is both an approach and a principle that should be applied across all aspects of care and treatment for tāngata whaiora Māori. Services should refer to Māori models of health,⁵⁴ such as Te Whare Tapa Whā,⁵⁵ to inform service development and delivery for tāngata whaiora Māori.

'Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.' *Ngā Paerewa outcome statement, subsection 6.1.*

⁵³ Ngā Paerewa, p. 9.

⁵⁴ www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha (accessed 29 March 2023).

⁵⁵ Te Whare Tapa Whā was developed by Sir Mason Durie in 1984.

Service providers should work in partnership with whānau, kaimahi Māori, cultural advisors, kaumātua and tohunga (where available) to promote least restrictive best practice.⁵⁶ Staff should engage these people in the first instance wherever practicable before considering using seclusion and restraint. They should offer people in these roles as advocates when seclusion or restraint occurs and, if tāngata whaiora wish, involve them in a person-centred debrief after a seclusion or restraint event.

Te Pou's *Evidence update* for least restrictive practice in Aotearoa New Zealand (November 2022) provides a Māori perspective on relevant research to identify the actions needed to eliminate the use of seclusion for tāngata whaiora Māori. It is a useful resource that will assist services to comply with the above guidelines.⁵⁷

4.2 Supported decision-making

Supported decision-making is a process that helps people to make their own decisions based on their will and preferences, so they have control of their life. The objective of supported decision making is to enable all people to exercise their full legal capacity, no matter what their cognitive status.⁵⁸

A supported decision-making approach assumes that all adults (with limited exceptions) have some level of ability to make decisions and that we all, at times, may need varying levels of support to make a decision or to express our will and preferences.

Supported decision-making is a central concept in the United Nations Convention on the Rights of Persons with Disabilities. Article 12 of that Convention (equal recognition before the law) requires Aotearoa New Zealand to take appropriate measures to provide persons with disabilities with access to the support that they need to exercise their legal capacity. Supported decision-making also gives effect to:

- the principles of Te Tiriti
- Right 7 of the Code of Rights, the right to make an informed choice and give informed consent)⁵⁹
- Right 8 of the Code of Rights, the right to support
- for psychiatrists, principles 5.6 and 5.7 of the RANZCP Code of Ethics.⁶⁰

People with experience of mental illness or distress can make decisions by themselves and for themselves, with support if needed. Sometimes having a serious mental illness

⁵⁶ Wharewera-Mika JP, Cooper E, Wiki N, et al. 2016. Strategies to reduce the use of seclusion with tangata whai i te ora (Māori mental health service users). *International Journal of Mental Health Nursing* 25(3): 258–65.

⁵⁷ d2ew8vb2gktr0m.cloudfront.net/files/resources/Least-restrictive-practice-evidence-update-November-2022.pdf (accessed 29 March 2023).

⁵⁸ Snelling J, Douglass A. 2019. Legal capacity and supported decision-making. In I Reuecamp, J Dawson (eds) *Mental Capacity Law in New Zealand*. Wellington: Thomson Reuters

⁵⁹ For the full wording of Right 7 see www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/ (accessed 29 March 2023).

⁶⁰ '5.6 Psychiatrists shall support the decision-making of a patient with impaired capacity so that, where possible, a decision can be validly made. 5.7 Psychiatrists shall seek consent from an appropriate substitute decisionmaker when valid consent cannot be given by the patient. This should respect the rights, will and preferences of the patient, and take into account any advance directive (see 5.10 for emergency situations).' See www.ranzcp.org/files/about_us/code-of-ethics.aspx (accessed 29 March 2023).

can affect people's cognitive ability or make it harder to make some decisions or to express a decision. Supported decision-making focuses on practical ways of providing the type and level of support that people might need to make decisions.

Treating teams should facilitate a collaborative process with a tangata whaiora to support them to express their wishes, ideally when the person is well. Teams should also enable discussion with family or whānau about such plans, to increase the chances of acting on wishes that the person expressed competently in the past.⁶¹ Discussions should include consideration of culturally appropriate care, especially for tāngata whaiora Māori.

Some practical ways of bolstering a person's capacity to determine and communicate a choice are to:

- use communication aids (for example, list options on a piece of paper with the person, including risks and benefits, and allow adequate time for the person to consider and discuss the options, including their concerns and preferences)
- develop advance directives or a joint crisis plan
- involve informal supporters such as one or more trusted whānau or family members, friends or peer support people.⁶²

The concept and practice of supported decision-making and how it relates to the Mental Health Act are detailed in *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*.⁶³

The Ministry of Social Development⁶⁴ website also has useful information and resources about supported decision-making.

4.3 Advance directives

Advance directives are a tool for supported decision-making. An advance directive can be a written or oral directive or instruction, in which a person informs health professionals about specific kinds of treatment that they would or would not want no matter how sick they are, or who they wish to be involved (or not involved) in their care. Advance directives are an important tool for allowing people to have a say over their future treatment.

Right 7(5) of the Code of Rights states that 'every consumer may use an advance directive in accordance with the common law'.

⁶¹ See Section 4.6.2 of Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

⁶² Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

⁶³ See Section 2: Supported decision-making in *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*.

⁶⁴ msd.govt.nz/about-msd-and-our-work/work-programmes/accessibility/supported-decision-making.html (accessed 29 March 2023).

An advance directive is also sometimes called a mental health advance preference statement, or MAP. Te Whatu Ora – Southern has developed and trialled a new advance directive tool in collaboration with the University of Auckland.^{65,66}

Aotearoa New Zealand research on MAPs has found that advance directives could increase service users' sense of autonomy and empowerment, and that there is strong overall support for advance directives among both service users and service providers.⁶⁷ There is some evidence suggesting that advance planning can reduce coercion (compulsory admissions) in mental health service.⁶⁸

There is some evidence that advance care planning can reduce non-consensual treatment in mental health services.^{69,70} Further research in this area is needed, but it stands to reason that if we can foster in tāngata whaiora a greater sense of control and respect, this would support a therapeutic engagement based on trust, which in turn may help prevent seclusion and restraint.⁷¹ More information about advance directives and the Mental Health Act is available in *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*.⁷²

4.4 Trauma-informed approaches

There is a growing awareness of the relationship between trauma and wellbeing. Definitions of trauma vary; the national mental health and addiction workforce development centres have used the following description.

Trauma is the lasting adverse effects on a person's or collective's functioning and mental, physical, social, emotional or spiritual wellbeing, caused by events, circumstances or intergenerational historical traumatic experiences.⁷³

For Māori, these experiences may include colonisation, racism and discrimination, along with health or social disparities.⁷⁴

⁶⁵ www.southernhealth.nz/getting-help-you-need/mental-health-and-addictions/mental-health-advance-preferences-statement (accessed 29 March 2023).

⁶⁶ Thom K, Lenagh-Glue J, O'Brien AJ, et al. 2019. Service user, whānau and peer support workers' perceptions of advance directives for mental health. *International Journal of Mental Health Nursing* 28(6): 1296–1305.

⁶⁷ Lenagh-Glue J, O'Brien A, Dawson J, et al. 2018. A MAP to mental health: the process of creating a collaborative advance preferences instrument. *New Zealand Medical Journal* 131: 1486.

⁶⁸ Tinland A, Loubière S, Mougeot F, et al. 2022. Effect of psychiatric advance directives facilitated by peer workers on compulsory admission among people with mental illness: a randomized clinical trial. *JAMA Psychiatry* 79(8): 752–9.

⁶⁹ de Jong MH, Kamperman AM, Oorschot M, et al. 2016. Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-analysis. *JAMA Psychiatry* 73(7): 657–64.

⁷⁰ Thornicroft G, Henderson C. Joint Decision Making and Reduced Need for Compulsory Psychiatric Admission. *JAMA Psychiatry* 73(7): 647–8.

⁷¹ Sashidharan SP, Mezzina R, Puras D. 2019. Reducing coercion in mental healthcare. *Epidemiology and Psychiatric Sciences* 28(6): 605–12.

⁷² Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

⁷³ Adapted from the Substance Abuse and Mental Health Services Administration (2012) in Te Rau Ora, Le Va, Werry Workforce Whāraurau, Te Pou. 2021. *Weaving together knowledge for wellbeing: Trauma informed approaches*.

⁷⁴ Pihama L, Smith LT, Evans-Campbell T, et al. 2017. Investigating Māori approaches to trauma informed care. *Journal of Indigenous Wellbeing* 2(3): 18–31.

We recognise that seclusion and restraint can be traumatising experiences for people, their whānau and staff.

Trauma-informed approaches⁷⁵ are grounded in an understanding of and responsiveness to the impact of trauma on people's lives. As noted by the workforce centres:

... trauma informed approaches focus on recognising and validating the trauma experiences of people and their potential to heal despite these events. This approach emphasises people's strengths and supports rather than focussing primarily on the negative outcomes or problems associated with trauma.⁷⁶

Trauma-informed care requires integration of a multilevel approach across the health system. Cultural awareness is essential to ensure that such approaches are effective for all people.

Trauma potentially affects 7 out of 10 Māori people, 8 out of 10 people in prison and 9 out of 10 people who have accessed mental health and addiction services (compared with 5 out of 10 people in the general population).⁷⁷ Additionally, young people who are admitted to mental health inpatient settings are likely to have experienced trauma in their life; more than a third of one large sample had experienced sexual or physical abuse.⁷⁸

Trauma-informed approaches are included in Te Pou's 7 'Real Skills' for health professionals working with people experiencing mental health and addiction needs and their whānau.⁷⁹ In addition, the RANZCP recommends that:

Individual psychiatrists enhance their own knowledge and skills in [trauma-informed practice]; in order that individuals receive care that maximises recovery potential, and minimises the risk of re-traumatisation for individuals, family, carers and staff.⁸⁰

Research has shown that the benefits of a trauma-informed approach include reduction in the use of seclusion and shortened adult inpatient stays.⁸¹ Additionally, a trauma-informed treatment approach with children and young people has been shown to reduce the number of physical restraints and seclusion events.⁸²

⁷⁵ The terms 'trauma informed care' and 'trauma informed practice' are also used.

⁷⁶ Te Rau Ora, Le Va, Werry Workforce Whāraurau, et al. 2021. *Weaving together knowledge for wellbeing: Trauma informed approaches*.

⁷⁷ Te Rau Ora, Le Va, Werry Workforce Whāraurau, et al. 2021. *Weaving together knowledge for wellbeing: Trauma informed approaches*.

⁷⁸ Bryson SA, Gauvin E, Jamieson A, et al. 2017. What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems* 11(1): 1–16.

⁷⁹ www.tepou.co.nz/initiatives/lets-get-real/seven-real-skills (accessed 30 March 2023).

⁸⁰ www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/trauma-informed-practice (accessed 31 March 2023).

⁸¹ Sweeney A, Clement S, Filson B, et al. 2016. Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal* 21(3).

⁸² Boel-Studt SM. 2017. A quasi-experimental study of trauma-informed psychiatric residential treatment for children and adolescents. *Research on Social Work Practice* 27(3): 273–82.

There are training programmes and resources to support mental health services and workers in Aotearoa New Zealand to take a trauma-informed approach, including when working with Māori and Pacific people and rangatahi who use services. These include:

- Te Pou's *Weaving together knowledge for wellbeing: Trauma informed approaches*: Recognising, understanding and responding to trauma in an informed way leads to positive outcomes for people and whānau in Aotearoa⁸³
- Te Pou's wider collection of resources and e-learning⁸⁴
- Le Va's guidance on a trauma-informed approach when working with Pasifika people⁸⁵
- Werry Workforce Whāraurau's training and resources focused on the needs of rangatahi/young people⁸⁶
- a video by Dr Kiri Prentice – about how tikanga-informed care is part of trauma-informed care for tāngata whaiora Māori⁸⁷
- A presentation by Dr Linda Tuhiwai Smith on kaupapa Māori approaches to trauma-informed care⁸⁸
- the RANZCP position statement on trauma-informed practice⁸⁹
- *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*.⁹⁰

4.5 Individualised support planning

Around two-thirds of seclusion episodes occur within 48 hours of admission. Services can respond to people's distress by engaging with them and developing an individualised, culturally appropriate support plan as early as possible.^{91,92}

Situations that a person may find distressing, and the support they need to deal with those situations, differ from person to person. Services therefore need to develop individualised support plans for supporting people in distress. Subsection 3.2 of Ngā Paewera, 'Taku huarahi ki te oranga My pathway to wellbeing', sets out the ways in which service providers must support individual pathways to wellbeing, including the

⁸³ Te Rau Ora, Le Va, Werry Workforce Whāraurau, et al. 2021. *Weaving together knowledge for wellbeing: Trauma informed approaches*.

⁸⁴ www.tepou.co.nz/initiatives/lets-get-real/trauma-informed-care-resources (accessed 30 March 2023).

⁸⁵ www.leva.co.nz/resources/a-trauma-informed-approach-when-working-with-pasifika-people/ (accessed 30 March 2023).

⁸⁶ www.wharaurau.org.nz (accessed 30 March 2023).

⁸⁷ www.youtube.com/watch?v=WKLKl9Ot_fE (accessed 30 March 2023).

⁸⁸ www.youtube.com/watch?v=GN3tu5FOOa0 (accessed 30 March 2023).

⁸⁹ www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/trauma-informed-practice (accessed 30 March 2023).

⁹⁰ Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

⁹¹ Jury A, Lai J, Tuason C, et al. 2019. People who experience seclusion in adult mental health inpatient services: An examination of health of the nation outcome scales scores. *International Journal of Mental Health Nursing* 28(1): 199–208.

⁹² www.tepou.co.nz/resources/evidence-update-for-reducing-seclusion-in-new-zealand (accessed 30 March 2023).

development of care or support plans. This process will be strengthened by a supported decision-making approach (see section 4.2 above).

Planning may include the use of culturally specific plans, wellness plans, crisis plans, relapse prevention plans and sensory modulation plans. Where a person has an advance directive (see section 4.3 above), this will shape their individual support planning. It is important that services co-develop individualised plans with people and, where appropriate, their whānau.

Specific plans may indicate which situations are likely to cause people distress, which behaviours indicate they need support and which type of support is effective. Planning should also consider any sensory differences or sensitivities the person may have (for example, people with autism may be distressed by touch), as well as substance use issues. This will help to reduce the use of seclusion and restraint where stressful situations can be avoided or managed with greater support, de-escalation techniques, and timely and effective alternatives to seclusion and restraint.

Plans should include consideration of communication needs people may have, such as whether they need an interpreter to communicate, including for New Zealand Sign Language. Services should consider the specific communication needs of people with an intellectual disability or neurodevelopment disorder.

4.6 Culturally safe support

Staff should be trained in culturally safe support. Ngā Paerewa defines cultural safety in section 0.3 as follows.

A principle that requires service providers and health care and support workers to examine themselves and the potential impact of their own culture in their interactions with people using a service. To practise cultural safety, service providers and health care and support workers acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of service provided.

‘Cultural safety benefits all patients and communities, and has a central role in health equity.’ *Medical Council of New Zealand*

Cultural safety recognises that people have different needs in relation to their cultural identity. It is an essential part of delivering person-centred care and achieving equity for Māori, Pacific peoples⁹³ and other groups of people who experience health disparities. The inclusion of whānau and kaimahi Māori is an important part of culturally safe support for tāngata whaiora Māori.

Cultural safety and the need for a cultural assessment is emphasised in Ngā Paerewa (in criteria 3.2.2 and 6.2.1) and the *Guidelines to the Mental Health Act* (see section 4.1.1: Culturally safe care).

⁹³ Ministry of Health. 2020. *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025*. Wellington: Ministry of Health.

Racism is increasingly recognised as a key determinant of health that results in avoidable and unfair disparities in health outcomes across racial or ethnic groupings. Within Aotearoa New Zealand, racism in the health and disability system and its impact on health outcomes has been well evidenced and researched. Ao Mai te Rā | The Anti-Racism Kaupapa is a Manatū Hauora initiative to combat racism in the health and disability system. Information and resources are available on the Ministry's website.⁹⁴

'Racism comprises racial prejudice and societal power and manifests in different ways. It results in the unequal distribution of power, privilege, resources and opportunity to produce outcomes that chronically favour, privilege and benefit one group over another. All forms of racism are harmful, and its effects are distinct and not felt equally.'

Ministry of Health's working definition for racism

Understanding systemic racism, our own biases and the way these biases may affect people in inpatient services is part of culturally safe practice.

The HQSC has developed e-learning resources on understanding bias in health care.⁹⁵ One of these is an e-learning module on implicit bias and best practice developed specifically for mental health and addiction staff; this is available on every service's learning platform.

The New Zealand Medical Council is committed to improving cultural safety; some resources are available on the Council's website.⁹⁶

Cultural safety may be improved with access to cultural supervision, which provides staff members with an opportunity to reflect on their practice of engaging with Māori.

4.6.1 Working with Pacific people

Pacific people experience seclusion at a significantly higher rate than non-Pacific and non-Māori people. Understanding Pacific culture and its influence on individual preferences and behaviour is an important part of effectively supporting Pacific people experiencing mental distress.

Kia Manawanui notes that for Pacific peoples, 'wellbeing encompasses mental, physical, spiritual, family, environmental, cultural and ancestral components, and includes cultural values that strengthen family and individual wellbeing, such as respect, reciprocity, collectivism and a focus on relationships.'⁹⁷

⁹⁴ www.health.govt.nz/about-ministry/what-we-do/combating-racism-health-system (accessed 30 March 2023).

⁹⁵ www.hqsc.govt.nz/our-programmes/patient-safety-day/publications-and-resources/publication/3866 (accessed 30 March 2023).

⁹⁶ www.mcnz.org.nz/our-standards/current-standards/cultural-safety/ (accessed 30 March 2023).

⁹⁷ *Kia Manawanui*, p.3.

Kia Manawanui promotes tailored responses for Pacific peoples, in line with the principles and aims set out in *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025*.⁹⁸

4.6.2 Respect for cultural identity

Cultural identity is an important aspect of wellbeing and recovery. Section 5 of the Mental Health Act requires anyone exercising powers under the Act in respect of a person to exercise that power 'with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.'

Section 65 of the Mental Health Act provides that 'Every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5.'

Services should refer to section 4.1.3 of the *Guidelines to the Mental Health Act* for guidance on respecting cultural identity and personal beliefs. This includes guidance on respecting a person's sexual orientation and gender identity. In addition, they should refer to *Supporting Aotearoa's Rainbow People: A practical guide for mental health professionals*.⁹⁹

Respecting someone's culture and identity is fundamental; it applies to all the approaches outlined in these guidelines.

4.7 Welcoming people and their whānau on admission

Welcoming people and their whānau on admission using tikanga processes and in a way that maintains people's mana and dignity can result in better outcomes. Māori and Pacific peoples may be more likely to access services that are welcoming and culturally safe.

A welcome or pōwhiri process helps create a safe environment, and starts people's healing journey. This can be achieved by being thoughtful about how staff greet tāngata whaiora on their arrival. A large team of staff may be intimidating. Simple actions like offering someone a drink or kai can give a message of manaakitanga (respect and caring).

Whakawhanaungatanga (getting to know each other) is an important way of establishing a connection with another person. To ensure a safe and supportive admission, staff should introduce themselves to tāngata whaiora, clearly explain who will be involved in their assessment, care, and treatment. Peer support workers should be involved in welcoming new admissions whenever possible.

In this context, suggestions from the Zero Seclusion: Safety and Dignity for all champions include:

⁹⁸ Ministry of Health. 2020. *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025*. Wellington: Ministry of Health.

⁹⁹ Fraser G. 2019. *Supporting Aotearoa's Rainbow People: A practical guide for mental health professionals*. Wellington: Youth Wellbeing Study and Rainbow YOUTH.

- providing kai and a welcoming environment
- providing a quiet, low-stimulus space
- listening to people’s concerns and needs – learning what has happened to them
- finding out what people’s triggers are
- ensuring people understand the admissions process, so there are no surprises.

Staff should involve whānau early on and throughout the process. When possible, they should let whānau stay with their loved one.¹⁰⁰ Māori may benefit from being welcomed with pōwhiri processes, images of journeys and recitation of the pūrākau (Māori creation narratives). Tikanga Māori and the presence of kaumātua and tohunga can help tāngata whaiora Māori feel welcome, safe and supported.

Creating a culturally healing environment may include having a kaumatua bless the space and cleansing the energies, providing access to natural greenspaces or creating shared spaces for kai Māori, waiata and other activities.¹⁰¹ It is important to be mindful of the physical environment; subtle changes such as wall murals or artwork can ensure this looks more welcoming.

Including whānau and/or support people may help people to feel safer and more comfortable. Where possible, the provision of an extra bed for a person’s partner or whānau member may be useful. This is especially important for young people and rangatahi Māori.

Staff should be aware of people’s experience pre-admission; for example, the way in which they were brought to the inpatient unit, or whether they have used substances – and how this may have contributed to their presentation on admission. This will help facilitate a safe and supportive welcome. Tāngata whaiora Māori may wish to have the support of a tohunga or kaumātua during the assessment process.

4.8 Sensory modulation or Whakaāio ā-rongo

Sensory modulation or whakaāio ā-rongo is an evidence-based, practical approach to support people when they are feeling distressed and overwhelmed. It involves supporting and guiding people in using their senses (sight, sounds, smells, touch, taste or movement) to self-manage and change their emotional state. Examples of sensory tools are music, aromatherapy, weighted modalities and comfortable seating. The approach has been used as one of multiple strategies to successfully reduce seclusion and restraint in mental health units.^{102,103} Whakaāio ā-rongo has been shown to be beneficial for Māori and their

¹⁰⁰ www.hqsc.govt.nz/assets/Our-work/Mental-health-and-addiction/Resources/ZeroSeclusionSummary_Nov20_Final.pdf (accessed 30 March 2023).

¹⁰¹ www.tepou.co.nz/resources/least-restrictive-practice-evidence-update-may-2021 (accessed 30 March 2023).

¹⁰² Lloyd C, King R, Machingura T. 2014. An investigation into the effectiveness of sensory modulation in reducing seclusion within an acute mental health unit. *Advances in Mental Health* 12(2): 93–100.

¹⁰³ Sutton D, Wilson M, Van Kessel K, et al. 2013. Optimizing arousal to manage aggression: A pilot study of sensory modulation. *International Journal of Mental Health Nursing* 22(6): 500–11.

whānau.¹⁰⁴ A designated sensory space and sensory resources should be available in mental health units.

Staff should be trained in sensory modulation to support people to manage their distress and develop self-regulation skills.

Staff should work with people and, if appropriate, their whānau, to identify and create a sensory modulation plan and toolkit to support people to self-manage and change their current emotional and behavioural responses to stressful situations. Sensory resources should be considered on an individual basis; all people have different sensory preferences.

Physical movements can also provide whakaāio ā-rongo and have a calming or grounding effect for tāngata whaiora Māori. More information can be found in Te Pou's *Least restrictive practice evidence update December 2022*.¹⁰⁵

There are cultural variations in the use of sensory modulation. For example, sensory modulation for tāngata whaiora Māori can come in the form of cultural practices such as haka and waiata. Tāngata whaiora Māori have reported feeling safe, being grounded in their bodies, and having an enhanced cultural identity during kapa haka.¹⁰⁶

More information on the use of sensory modulation can be found on the Te Pou¹⁰⁷ and HQSC¹⁰⁸ websites.

4.8.1 Weighted blankets

Weighted blankets are often used as a form of sensory therapy for people experiencing stress or anxiety, as they can have a calming influence and assist with emotional and physical regulation. Studies have demonstrated that weighted blankets are safe and effective for reducing anxiety in adults within inpatient mental health hospitals.^{109,110}

Services should take a trauma-informed approach to the use of weighted blankets; being covered may be re-traumatising for some people. Staff must ensure that people can remove the blanket on their own and monitor them for any discomfort during their use.

¹⁰⁴ Schlotjes ER, Smith MM. 2022. Open doors: Sensory rongo for Māori. *New Zealand Journal of Occupational Therapy*, 69(1): 10–16.

¹⁰⁵ www.tepou.co.nz/resources/least-restrictive-practice-evidence-update-december-2022 (accessed 30 March 2023).

¹⁰⁶ Hollands T, Sutton D, Wright-St.Clair V, et al. 2015. Māori mental health consumers' sensory experience of kapa haka and its utility to occupational therapy practice. *New Zealand Journal of Occupational Therapy* 62(1): 3–11.

¹⁰⁷ www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/sensory-modulation (accessed 30 March 2023).

¹⁰⁸ www.hqsc.govt.nz/news/mental-health-and-addiction-quality-improvement-programme-update/ (accessed 30 March 2023).

¹⁰⁹ Mullen B, Champagne T, Krishnamurty S, et al. 2008. Exploring the safety and therapeutic effects of deep pressure stimulation using a weighted blanket. *Occupational Therapy in Mental Health* 24: 65–89.

¹¹⁰ Champagne T, Mullen B, Dickson D, et al. 2015. Evaluating the safety and effectiveness of the weighted blanket with adults during an inpatient mental health hospitalization. *Occupational Therapy in Mental Health* 31(3): 211–33.

Guidelines for the safe use of weighted blankets can be found in Te Pou's *Least restrictive practice evidence update October 2021*.¹¹¹

4.9 Restorative practice

Restorative practice (also referred to as restorative justice) is an emerging practice within health care. It involves 'a voluntary, relational process whereby those with a personal stake in an offence or conflict or injustice come together, in a safe and respectful environment.'¹¹²

Restorative approaches aim for a collective understanding of an adverse event, which can help clarify responsibilities, inform action, and heal individuals and relationships.¹¹³

The principles of restorative practice align well with tikanga Māori concepts of justice and collective responsibility.¹¹⁴ We strongly encourage services to consider the use of restorative practices with tāngata whaiora Māori¹¹⁵ and their whānau. In doing so, services can demonstrate their commitment to working in partnership with Māori.

The benefits of restorative practice to people who have suffered harm, or whose whānau has suffered harm, as a result of an incident can include empowerment, strengthened relationships, healing and forgiveness.

Within a health care setting, restorative approaches have been shown to create a more open and trusting culture, and have resulted in increased engagement, increased psychological safety and reduced stress for staff.¹¹⁶

The HQSC has promoted restorative practices as a way of responding to adverse events in health care settings. Information and resources are available on its website.¹¹⁷ A restorative approach is likely to help services conduct a meaningful, person- and whānau-centred debrief after episodes of emergency restraint and seclusion, as Ngā Paerewa requires (in criteria 6.2.5 and 6.4.5).

¹¹¹ www.tepou.co.nz/resources/least-restrictive-practice-evidence-update-october-2021 (accessed 30 March 2023).

¹¹² Marshall CD. 2020. Restorative justice. In: *Religion Matters*. Singapore: Springer, pp. 101–17.

¹¹³ www.hqsc.govt.nz/news/blog-using-a-restorative-approach-to-respond-to-adverse-events/ (accessed 30 March 2023).

¹¹⁴ www.resolution.institute/documents/item/1774 (accessed 30 March 2023).

¹¹⁵ Wharewera-Mika JP, Cooper EP, Wiki NR, et al. 2016. Strategies to reduce the use of seclusion with tāngata whai i te ora (Māori mental health service users). *International Journal of Mental Health Nursing* 25(3): 258–65.

¹¹⁶ Kaur M, De Boer RJ, Oates A, et al. 2019. Restorative just culture: a study of the practical and economic effects of implementing restorative justice in an NHS trust. In *MATEC Web of Conferences* (Vol. 273, p. 01007). EDP Sciences.

¹¹⁷ www.hqsc.govt.nz/our-work/system-safety/restorative-practice/ (accessed 30 March 2023).

4.10 The role of whānau and family

Section 5 of the Mental Health Act requires anyone exercising powers under the Mental Health Act in respect of a person to exercise those powers 'with proper recognition of the importance and significance to the person of the person's ties with his or her family, whānau, hapū, iwi, and family group' and 'proper recognition of the contribution those ties make to the person's wellbeing'.

Family, whānau, friends or partners can provide useful information about situations that may cause tāngata whaiora distress and help prevent the use of seclusion and restraint. They can also be an effective support for tāngata whaiora when they are distressed, which may help to further prevent the use of seclusion and restraint. This is particularly important to consider when working with children or young people, as family and whānau play a central role in their lives.

Services should consider how to incorporate the knowledge of tāngata whaiora held by whānau, family, friends or partners into support and treatment plans. They should also ensure that tāngata whaiora are able to enjoy contact with whānau, family, friends or partners while they are in an inpatient unit. This can help reduce stress, and potentially reduce the requirement for seclusion or restraint.

Many children and young people are admitted to inpatient settings away from their hometown. In this case, services should proactively support visits home and contact with people at home, including by video technology.

Te Pou provides an online learning resource on working with whānau as part of its *Let's get real* skills framework.¹¹⁸

¹¹⁸ See www.tepou.co.nz/initiatives/lets-get-real/working-with-whānau (accessed 30 March 2023).

5 Considerations for children and young people

While the guidance and methods outlined above are relevant and beneficial to use with children and young people, this section presents specific considerations. It also sets out methods that have been proven effective at minimising the use of seclusion and restraint with children and young people. Services should actively uphold the Crown's obligations under Te Tiriti when working with tamariki and rangatahi Māori. It is important to consider the cultural needs of tamariki and rangatahi, keeping in mind that they may be on a journey of cultural discovery.

Children and young people have a range of unique needs, vulnerabilities and characteristics that services should consider when planning and providing care, including in environments where seclusion and restraint may be used.

Staff should remember their obligations under the United Nations Convention on the Rights of the Child when working with children and young people. Article 37(c) says:

Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner, which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.

The younger a person is, the greater the duty of care is. It is important for staff to consider developmental age and the vulnerabilities associated with this, as well as chronological age, when caring for children and young people.

5.1 Consent to treatment under the Mental Health Act

It is important that a young person, or their parent/guardian, provides appropriate consent to mental health treatment. Tamariki and rangatahi should be involved in decisions about their care and treatment where possible.

For people aged 16 and over, section 87 of the Mental Health Act states that the consent of a parent or guardian to any assessment or treatment for mental disorder is not sufficient consent for the purposes of that Act. In relation to compulsory treatment, this

means that consent for young people aged 16 and over must comply with the requirements of section 59 of the Mental Health Act.¹¹⁹

There should be clear demonstration that children and young people have been talked to and that best-practice *Gillick* principles are used.¹²⁰ When a child or young person cannot consent, staff should record the reason why.

5.2 Understanding children and young people

Staff should have a good understanding of youth culture. They should also be aware of what is important to children and young people, how they like to express themselves and how they experience distress and mental health issues. These factors will differ for each child or young person; staff should record their notes in this regard on individual support plans.

Service providers should be aware of the professional development needs of staff working in environments where children and young people may be subject to seclusion and restraint. Staff should be supported to develop a good understanding of child and youth development and communication styles.

Staff should recognise that children and young people:

- are developing autonomy
- may experience age-related increased risk taking
- may have varying emotional control and reasoning ability
- may have difficulty with flexibility/adaptability
- may experience a heightened power imbalance with adults.¹²¹

Section 86 of the Mental Health Act states that, wherever practicable, assessment examination of a person who is under the age of 17 years shall be conducted by a psychiatrist practising in the field of child psychiatry. It may also be appropriate for a child psychiatrist to assess people aged over 17 years; staff should consider this on an individual basis.

Where possible, staff working with children and young people should reflect the demographic and cultural characteristics of the young people who use the service. In relation to what young people are looking for in relationships with mental health professionals, studies have found that 'young people were looking for something beyond title or competence, for something that simply felt "nice" and "comfortable".'

¹¹⁹ See Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health for guidance on consent and second opinions for treatment under the Mental Health Act.

¹²⁰ Gillick competence is about whether a child, regardless of their age, can give informed consent to, or refuse consent to, a treatment.

¹²¹ Christie D, Viner R. 2005. Adolescent development. *BMJ (Clinical research ed)* 330(7486): 301–4.

For some young people, there was an automatic sense of connection with younger clinicians who they felt shared their worldview.¹²²

Services should identify, and have a record of, staff members who a child or young person have developed a strong therapeutic relationship with, and make regular opportunities for the child or young person to connect with these staff members.

5.3 Approaches to prevent the use of seclusion and restraint

The use of seclusion and restraint on children and young people in an inpatient setting has been found to negatively affect the overall value and safety of care.¹²³ Additionally, children's experience of seclusion and restraint is negative; children have reported feelings of fear, abandonment and punishment following seclusion and restraint.¹²⁴ Staff should make every effort to utilise alternative methods before considering the use of seclusion or restraint.

Models that have shown a reduction in the use of seclusion and restraint with children and young people include:

- Collaborative Problem Solving (also called Collaborative & Proactive Solutions)¹²⁵
- the Attachment, Regulation and Competency model¹²⁶
- trauma-informed approaches^{127,128}
- Mindfulness-Based Stress Reduction Training.¹²⁹

While these models have been effective at reducing seclusion and restraint, authors emphasise the importance of overall good care in reducing the use of seclusion and restraint with children and young people. Good care requires staff that are equipped with a thorough understanding of the factors that may drive the behaviour of young people, including understanding how limits are set and how expectations expressed by adults may influence or precipitate those behaviours, leading to an approach that emphasises crisis prevention over crisis management.¹³⁰

¹²² Gibson K. 2022. *What Young People Want from Mental Health Services: A youth informed approach for the digital age*. London: Routledge.

¹²³ Magnowski SR, Kick D, Cook J, et al. 2020. Algorithmic Prediction of Restraint and Seclusion in an Inpatient Child and Adolescent Psychiatric Population. *Journal of the American Psychiatric Nurses Association* 28(6): 464–73.

¹²⁴ Montreuil, M, Thibeault C, McHarg L, et al. 2018. Children's moral experiences of crisis management in a child mental health setting. *International Journal of Mental Health Nursing* 27(5): 1440–8.

¹²⁵ Black V, Bobier C, Thomas B, et al. 2020. Reducing seclusion and restraint in a child and adolescent inpatient area: implementation of a collaborative problem-solving approach. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists* 28(5): 578–84.

¹²⁶ Hodgdon HB, Kinniburgh K, Gabowitz D, et al. 2013. Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal of Family Violence* 28(7): 679–92.

¹²⁷ Boel-Studt SM. 2017. A quasi-experimental study of trauma-informed psychiatric residential treatment for children and adolescents. *Research on Social Work Practice* 27(3): 273–82.

¹²⁸ Te Pou o te Whakaaro Nui, Ministry of Health. 2018. *Let's Get Real: Real Skills for working with people and whānau with mental health and addiction needs*. Auckland: Te Pou o te Whakaaro Nui.

¹²⁹ Perers C, Bäckström B, Johansson B, et al. 2021. Methods and Strategies for Reducing Seclusion and Restraint in Child and Adolescent Psychiatric Inpatient Care. *Psychiatric Quarterly* 93(1): 107–36.

¹³⁰ Bryson SA, Gauvin E, Jamieson A, et al. 2017. What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems* 11(1): 1–16.

Part Three: Safely using seclusion and restraint as a last resort

Where it has not been possible to avoid using seclusion and restraint, services must use these practices safely and to the minimal extent necessary to ensure the safety of the person being restrained or secluded and those around them.

This section sets out the requirements for using seclusion and restraint as a last resort, in alignment with the criteria of Ngā Paerewa. Inpatient mental health services must adhere to these requirements.

For the purposes of these guidelines, and for the sake of clarity, the term 'last resort' refers to a situation in which all other suitable non-restrictive approaches have been tried and have failed to ensure safety. A 'last resort' intervention must be a proportionate response to concerns about the safety of the person and others.

6 Principles for the use of seclusion and restraint

These principles have been adapted from section 14.7.3 'Principles on the use of restraint' in the *Guidelines to the Mental Health Act*.¹³¹

The principles are as follows.

The decision to use seclusion or restraint is based on maintaining the safety of the person experiencing distress, staff, or others in the inpatient environment, in an emergency.¹³² Seclusion or restraint is only used to ensure the safety of people accessing the service, staff or others and as an emergency intervention when all other least restrictive strategies and approaches have been tried without positive effect.

Restraint must be used with the least amount of force necessary to maintain the safety of the person experiencing distress, staff or others in the inpatient environment.

¹³¹ Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

¹³² An emergency is defined as a serious, unexpected and dangerous situation requiring immediate action.

Seclusion and restraint should only be used once all other options have been explored.

The duration of seclusion or restraint must be for the shortest possible time it takes to safely manage the situation.

Seclusion and restraint must be guided by **legal, ethical and trauma-informed** care principles.

If seclusion or restraint is necessary, staff must **uphold the dignity, privacy, preferences, cultural needs and mana of people to the greatest extent possible at all times**. They must address any breaches of the above with the person (and their whānau if appropriate) as soon as it is practicable to do so (including through debriefing processes as required by Ngā Paerewa and set out in section 9.1.1 below).

Staff must maintain **open and compassionate** communication with people through a seclusion or restraint episode.

Health services must not use restraint for punitive reasons, to manage staff shortages or to manage people in unfit-for-purpose facilities.

Restraint techniques must be aligned with **international human rights standards** and not inflict pain on tāngata whaiora.

7 Safely using restraint under the Mental Health Act

Services should only use restraint once less restrictive measures have proved unsuccessful, and only to the extent that is 'reasonably necessary in the circumstances' (section 122B of the Mental Health Act). Restraint is a serious intervention requiring robust clinical justification and oversight. If staff use restraint, they have a duty of care to mitigate the psychological and physical harms that can occur.

As mentioned, Ngā Paerewa in Outcome 6 'Here Taratahi Restraint and Seclusion' requires that 'services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.'

7.1 Legislation governing restraint

Restraint – particularly personal and physical restraint – is considered a use of force under section 122B of the Mental Health Act. Section 122B outlines the circumstances in which force may be used and states that it must only be 'such force as is reasonably necessary in the circumstances'. The information in this section must be read in conjunction with the *Guidelines to the Mental Health Act* (in particular, section 15.7), which provides guidance for the use of force under the Mental Health Act.

Restraint is also permitted in certain circumstances under the Crimes Act 1961 to prevent injury to self or others. Section 151 of the Crimes Act provides that everyone who has actual care or charge of a vulnerable person has a legal duty 'to take reasonable steps to protect that person from injury'. Section 48 is also relevant; it provides that everyone is justified in using, in defence of themselves or another person, force that they believe is reasonable to use given the circumstances. Appendix A sets out the relevant sections of the Crimes Act.

7.2 Environmental restraint

These guidelines define environmental restraint as 'where a service provider intentionally restricts a person's normal access to their environment: for example, where a person's normal access to their environment is intentionally restricted by locking or blocking doors.'

Environmental restraint limits a person's normal freedom of movement and includes the locking of doors of an inpatient unit or limiting a person's access to certain parts of a unit. Such actions may deprive someone of their right to company (section 71 of the

Mental Health Act) or their right to not be arbitrarily detained (section 22 of the New Zealand Bill of Rights Act).

It is important to note that environmental restraint used to influence the behaviour of one person may have unintended consequences for another person. For example, in a group setting such as a mental health inpatient unit, locking a room or area can limit the rights and freedoms of other people living in that unit. Staff should take this into consideration when implementing any restrictive practice.

If it is considered necessary to restrict the movement of a person who presents an imminent risk of harm to others, we recommend that this should be part of a planned approach including actions to minimise the need for more restrictive restraint. If the use of environmental restraint does not achieve the intended purpose, staff should investigate and use alternative strategies. This may include an external assessment process to determine the most appropriate level of care.

Where a decision is made to limit a person's normal freedom of movement within the environment of an inpatient mental health unit, staff must record this as an episode of environmental restraint in the service's reportable event system. Directors of Area Mental Health Services must report use of restraint to the Director of Mental Health in their quarterly reports.

Where staff lock internal doors, they must restore access to all the areas of the unit that people would ordinarily have access to as soon as it is practicable and safe.

People who need mobility aids, such as a wheelchair or walking aid, should not be prevented from accessing those aids as a means of limiting their movement. This may constitute a breach of their human rights and the Code of Rights.

7.2.1 Environmental restraint and seclusion

Environmental restraint can be viewed as a continuum; seclusion is the most restrictive form. A situation in which a person is alone while their movement is restricted effectively meets the definition of seclusion. Determining the point at which environmental restraint becomes seclusion will depend on factors such as the purpose of the restriction, the impact on the person and ward design. To help determine this, services can ask person-centred, rights-based questions to understand the likely impact on the person. For example:

- Is the intent of the restriction to deprive the person of company?
- Can the person socially interact with others?
- Can the person move freely around within the area, access their belongings and engage in activities (such as reading or watching television)?

If the intent of the restriction (aside from ensuring the safety of others) is to deprive the person of company, then the restriction is likely to meet the definition of seclusion, regardless of the exact location. However, if the person being alone is incidental to the reason for the restriction, the restriction is more likely to fit the definition of environmental restraint. This may be the case, for example, where staff decide to separate a person who is thought to pose a danger to others on the unit, and there is no

other tangata whaiora who can safely share the space with that person. In a small inpatient unit, there may only be one person admitted in a particular area, so that their being alone is incidental. In these scenarios the person can move around within the area in which they are restrained, and have a choice of activities. In this sense, the intervention is less restrictive than seclusion, and may be considered environmental restraint.

Whenever a person is in an area without other tāngata whaiora, staff should ensure that the person has the opportunity for social interaction if they wish. This could include enabling contact with the person's whānau or friends in person, by phone or through electronic communication. Understanding people's preferences is important. People do not necessarily expect or want to be around others at all times (for example, in an inpatient unit it is reasonable to expect solitude in one's bedroom, especially at night). However, if a person is consistently deprived of company, this may amount to seclusion.

Where a person has expressed a preference for solitude and is voluntarily staying in an area (such as a de-escalation space) on their own, this is not a form of restraint as long as staff do not prevent the person from leaving that area at will.

7.2.2 Locked units

In a locked unit, such as a secure forensic unit or general mental health high dependency unit, the locked exit is a permanent aspect of service delivery to meet the safety needs of people receiving treatment who staff have assessed as needing that level of care and support. This is not considered a form of environmental restraint for the purposes of these guidelines.

A person who is receiving treatment voluntarily should only be placed in a locked unit with their informed consent; this must be documented in their clinical notes. Not allowing a person receiving treatment voluntarily to leave a locked unit without a clear legal basis constitutes arbitrary detention. Services should inform voluntary tāngata whaiora that they can exit the unit as soon as reasonably practical if they wish, and display clear signage informing voluntary tāngata whaiora how to exit a locked unit.

This guidance does not apply to the locking of entry/exit doors to units for safety and security reasons (for example, at night), and to stop people from entering the unit who may pose a threat to the safety of tāngata whaiora, staff, whānau or visitors in the unit.

7.2.3 Locking of bedroom doors overnight in regional forensic mental health services (previously known as night safety procedures)

As of 30 December 2022, the use of night safety procedures is no longer permitted in mental health units, as set out in the *Night Safety Procedures: Transitional Guideline*.¹³³

¹³³ Ministry of Health. 2018. *Night Safety Procedures: Transitional Guideline*. Wellington: Ministry of Health.

A 'night safety procedure' was the practice of locking a service user in their bedroom overnight for the purposes of safety. The *Night Safety Procedures: Transitional Guideline* recognised that locking a person in their room is a restrictive practice and constitutes a use of force.

From 31 December 2022, where a person's bedroom door is locked overnight for the purposes of safety, this must be recorded as environmental restraint and reported to the Director of Mental Health at Manatū Hauora. The Director expects the Regional Forensic Mental Health Services to minimise and work towards eliminating the locking of doors overnight.

Forensic services may legitimately need to restrict a person's movement at night for the purposes of safety by locking the door to their room. This should only occur on the basis of an individual assessment and only when no other safe and effective intervention is possible. It should not occur as part of a routine admission or therapeutic procedure, be administered as discipline or be used as a replacement for adequate levels of staff or resources. A 'blanket' policy of locking bedroom doors overnight in forensic units is unacceptable.

7.3 Decisions to approve restraint

Services may sometimes make a decision to approve restraint once all other suitable non-restrictive approaches have been tried and have failed to ensure safety. Such decisions must be consistent with Ngā Paerewa criterion 6.2.1, which requires decisions to approve restraint for a person receiving services to be made:

- as a last resort, after all other interventions or de-escalation strategies have been tried or implemented
- after adequate time has been given for cultural assessment
- following assessment, planning, and preparation, which includes available resources able to be put in place
- by the most appropriate health professional¹³⁴
- when the environment is appropriate and safe.

In an emergency, where it is not possible to try other less restrictive options to maintain the safety of tāngata whaiora and staff, it may not be possible to meet each of the criteria set out above.

7.3.1 Physical and psychological health considerations

Staff must monitor a person's physical health during a period of restraint. No use of restraint is completely safe. Each restraint episode should be for the shortest possible time to minimise harm. Personal restraint has physical health risks for the person being

¹³⁴ Either a registered nurse or a medical practitioner.

restrained that can result in injury or death.¹³⁵ In general, people who experience acute mental distress factors have poorer physical health, which puts them at higher risk of physical harm occurring during a restraint event. Research has also shown that young people are at a higher risk of injury or harm resulting from restraint.¹³⁶

A person's risk of injury or death resulting from a restraint event increases with the presence of several factors, including:

- pre-existing health conditions
- excited delirium/acute behavioural disturbance
- substance use¹³⁷
- positional asphyxia
- prone positioning,¹³⁸ which increases the risk of breathing difficulty. Prone restraints are not supported by these guidelines or the SPEC training for safety reasons; services should not use them.

The longer the restraint episode lasts, the more likely that injury or death may occur.¹³⁹ There is no safe window of time for a restraint episode.¹⁴⁰ Researchers have found the time that individuals were held in a prone restraint before fatal collapse ranged from 2 to 12 minutes.¹⁴¹

As noted in section 2.1, there are also psychological consequences of using restraint that services need to mitigate as much as possible when using restraint. This includes the likelihood of a person's anxiety, aggression or distress escalating during an episode of restraint.

Following an episode of restraint, staff should consider the need for a medical examination to assess for injuries or aggravation of underlying medical conditions caused by the restraint. Staff should report any adverse events and follow them up in accordance with their policies.

It is important for staff to maintain relational safety and wairuatanga (spiritual) safety as much as possible when using restraint.

¹³⁵ Hollins L. 2017. The NICE 10 minute physical restraint rule: A discussion of the relative risks. *Journal of Psychiatric and Mental Health Nursing* 24(9–10): 719–26.

¹³⁶ Mohr WK, Petti TA, Mohr BD. 2003. Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry* 48(5): 330–7.

¹³⁷ Hollins L. 2017. The NICE 10 minute physical restraint rule: a discussion of the relative risks. *Journal of Psychiatric and Mental Health Nursing* 24(9–10): 719–26.

¹³⁸ Steinberg A. 2021. Prone restraint cardiac arrest: A comprehensive review of the scientific literature and an explanation of the physiology. *Medicine, Science, and the Law* 61(3): 215–26.

¹³⁹ Hollins L. 2017. The NICE 10 minute physical restraint rule: a discussion of the relative risks. *Journal of Psychiatric and Mental Health Nursing* 24(9–10): 719–26.

¹⁴⁰ McKenna B, Furness T, Maguire T. 2014. *A literature review and policy analysis on the practice of restrictive interventions*. Melbourne: Department of Health & Human Services.

¹⁴¹ O'Halloran RL, Frank JG. 2000. Asphyxial death during prone restraint revisited: A report of 21 cases. *American Journal of Forensic Medicine and Pathology* 21(1): 39–52.

7.3.2 Other safety considerations

Before making a decision to use restraint, staff should consider a person's trauma history, their possible recent substance use and their cultural needs. They should seek relevant cultural advice to maintain cultural safety. A person's sensory differences or sensitivities (for example, some people may be distressed by touch), and communication needs are also an important part of the decision.

7.3.3 Use of security staff for restraint events

The involvement of security staff in responding to incidents posing an immediate risk of harm may be appropriate if those staff have the necessary training (such as SPEC) and their interaction with tāngata whaiora is limited. In these circumstances, security staff should be working under the direction of a registered health professional. Services should ensure that their policies, procedures and training methods set out clear boundaries for engagement by security staff. Security staff should not be involved in routine interventions.

Restraining someone damages trust and the therapeutic relationships they have with staff. It is preferable that mental health professionals spend their time engaging positively with tāngata whaiora using the approaches set out in these guidelines.

Security staff should not be involved in any therapeutic interventions in mental health units (noting that seclusion and restraint are not therapeutic).

8 Safely using seclusion under the Mental Health Act

The outcome Ngā Paerewa expresses in Outcome 6 'Here Taratahi Restraint and Seclusion' is that 'services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained'.

Manatū Hauora is committed to supporting the Zero Seclusion: Safety and Dignity for All project and criterion 6.4.1 of Ngā Paerewa, which states that service providers shall work towards being seclusion free.

Seclusion may be lawfully used if the requirements set out in section 71 of the Mental Health Act are met (as described below). However, under these guidelines, providers should only use seclusion under urgency or in emergency situations once all other less restrictive options have been tried, or where other less restrictive options are not possible to maintain the safety of tāngata whaiora and staff. This is consistent with Ngā Paerewa, which provides that services must only make the decision to approve restraint (including seclusion) for a person receiving services as a last resort, after they have tried all other interventions or de-escalation strategies (criterion 6.2.1).

Service providers shall work towards being seclusion free. *Ngā Paerewa criterion 6.4.1*

Effective ways to support people in distress and help avoid the use of seclusion include:

- bringing them into a quiet space
- actively listening to their concerns and needs
- learning about what happened to them, their triggers and what calms them
- offering them food or a drink
- involving their whānau early on, and throughout, if the person wishes
- a sensory modulation plan.

While the Mental Health Act permits seclusion, we now understand that seclusion has no known therapeutic value. If seclusion cannot be avoided, staff have a duty of care and accountability to mitigate the potential psychological and physical harm that seclusion can cause. It is essential that it is used safely and under the appropriate circumstances.

8.1 Seclusion under the Mental Health Act

Section 71 of the Mental Health Act states that every patient is entitled to the company of others, except that patients may be placed in seclusion if the following circumstances are met:

- a. seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients [see note below]
- b. a patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services
- c. except as provided in paragraph (d), seclusion shall be used only with the authority of the responsible clinician
- d. in an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician
- e. the duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129(1)(b).

While the Mental Health Act uses the words 'care or treatment' in seclusion, it is now widely understood that that seclusion is not therapeutic and may be harmful.

8.2 Individualised care

Staff must make decisions on the use of seclusion on an individual basis. Staff may be able to refer to a person's advance directive when considering the use of seclusion.

Staff should consider a person's trauma history and cultural needs before making a decision on the use of seclusion, including by seeking relevant cultural advice. A person's sensory differences or sensitivities (for example, some people may be distressed by touch) and communication needs must form part of the decision.

8.3 Physical and psychological health considerations

It is essential to the safety of tāngata whaiora that staff consider their physical health when using seclusion. Staff must apply extreme caution when considering seclusion in the following circumstances:

- where the person is receiving medication and there is:
 - evidence of altered or fluctuating levels of consciousness, or other neurological side effects

- likelihood of respiratory suppression or other cardiovascular side effects
- physical deterioration
- where the person needs intensive assessment and/or observation, especially where there is a history suggestive of significant trauma, ingestion of unknown drugs/substances or medical comorbidities
- where the person is intoxicated or has recently used substances
- where the person has a physical illness or injury requiring specific physical treatment
- where there is the presence or likelihood of self-injurious behaviour (note that seclusion should not be used when the person is assessed as at risk of self-harm and poses no imminent danger to others)
- where there is a likelihood of escalation of anxiety, aggression or distress or evidence of a previous adverse response
- with children or young people
- with older adults
- where a person has a disability or underlying health issues.

The use of seclusion and restraint is highly likely to escalate a person's anxiety, aggression or distress.

8.4 Providing a safe environment (seclusion rooms)

Seclusion rooms need to be able to maintain a person's dignity and comfort without posing a risk for the person or staff.¹⁴² While this may be challenging, it is important to create an environment that supports people's recovery and safety. Services should refer to the current Australasian Health Facility Guidelines for seclusion room requirements.¹⁴³

Staff should only place people in seclusion in a room or area that has been designated or approved by the DAMHS (under section 71 of the Mental Health Act and criterion 6.4.4 of Ngā Paerewa). At a minimum, a seclusion room must have:

- adequate light, heat and ventilation
- a safe way of accessing drinking water
- means to easily observe the person that also allows the person to see the head and shoulders of the observer
- means for a person to easily call for attention and connections with staff (such as call bells)
- fittings recessed to avoid potential for harm
- furnishings (other than bedding) that are fixed to avoid the potential for harm
- doors opening outwards flush with the walls

¹⁴² Shalev S. 2020. *Time for a Paradigm Shift: A Follow Up Review of Seclusion and Restraint Practices in New Zealand*. Wellington: Human Rights Commission.

¹⁴³ healthfacilityguidelines.com.au/ (accessed 30 March 2023).

- a means of orientation and connection (eg, a visible clock or calendar, or access to news)
- access to toileting, washing and showering facilities in or adjacent to the seclusion room (this may not be possible in existing seclusion rooms but should be implemented for new facilities). The use of cardboard receptacles for toileting is degrading and should be avoided wherever possible
- access to 2-way communication
- access to an equally safe external area to assist with reintegration
- an external window for natural light (this may not be possible in existing seclusion rooms but should be implemented for new facilities).

Services should consider improving the physical appearance of seclusion rooms, to create an environment that is supportive of recovery and wellbeing.¹⁴⁴ Seclusion rooms have been criticised for their 'barren' and 'drab' appearance.¹⁴⁵ The colour of seclusion rooms may help to create a calm environment for people in seclusion. When considering changes to the colour or appearance of seclusion rooms, services should engage in co-design with people who have experienced seclusion, cultural advisors and peer support workers.

Subject to safety considerations, services should consider people's access to personal items when they are in seclusion rooms, and should ensure they have access to the resources they need to meet their spiritual and cultural needs.

Services should also consider people's ability to exercise personal autonomy while in seclusion. Where possible, people should be able to make decisions for themselves, and not rely on staff to perform basic tasks for them. This includes decisions about the light and temperature of the seclusion room and access to drinking water and toileting.

Services should consider de-commissioning/re-purposing seclusion rooms in the interests of further eliminating the practice.

8.5 Commencing and ending seclusion

8.5.1 Commencing seclusion

A period of seclusion will commence when a person is 'placed alone in a room or area, at any time and for any duration, from which they cannot freely exit' (Ngā Paerewa).

Staff should explain the reason for the use of seclusion to the person when placing them in seclusion (and at any extensions of the episode of seclusion).

¹⁴⁴ Seppänen A, Törmänen I, Shaw C, et al. 2018. Modern forensic psychiatric hospital design: clinical, legal and structural aspects. *International Journal of Mental Health Systems* 12: 58.

¹⁴⁵ Shalev S. 2017. *Thinking outside the Box? A Review of Seclusion and Restraint Practices in New Zealand*. Wellington: Human Rights Commission.

Staff should document their reasons for seclusion. The documentation must specify what needs to occur for seclusion to end, and record that staff have informed tāngata whaiora of what changes must be observed for seclusion to end.

8.5.2 Each initial seclusion episode is for a maximum of 2 hours

Each new seclusion episode shall be for a maximum of 2 hours. People may leave seclusion before the 2-hour period if it is no longer needed. The decision to place a person in seclusion must be taken by 2 suitably qualified clinicians¹⁴⁶ and authorised by the responsible clinician (if they are not one of the 2 clinicians).¹⁴⁷ Staff should explain the reasons for continued use of seclusion to the person in seclusion and document them.

8.5.3 Extending seclusion beyond 2 hours

Staff should end the seclusion episode as soon as possible. For seclusion to be extended beyond 2 hours, the responsible clinician or 2 suitably qualified clinicians must assess the person's wellbeing and provide a reason for the continued use of seclusion. Staff should notify the responsible clinician as soon as practicable (if they are not one of the 2 clinicians). They should explain the reason for the continued use of seclusion to the person in seclusion and document it.

8.5.4 8-hourly assessments and care

If staff agree that seclusion is still needed after the initial 2 hours, they may extend the seclusion episode may for up to an additional 8 hours. Throughout this 8-hour period, staff must continue to assess whether seclusion is still needed every 2 hours as described in section 8.6.3 below.

Before the end of an 8-hour period, 2 suitably qualified clinicians must assess the person and decide whether to further extend seclusion for up to another 8 hours. One of these clinicians should be the responsible clinician, if they are available. Staff should document a record of the 8-hour assessments. If the responsible clinician is not one of the clinicians who decide to further extend the seclusion episode, they should be notified of the decision as soon as practicable.

Staff must either end the seclusion episode or record the reason for continued use.

¹⁴⁶ A suitably qualified clinician is either a registered nurse or a medical practitioner. The registered nurse must have mental health training and experience (as has been defined for the completion of certificates under section 8B of the Mental Health Act) and must have completed an undergraduate or postgraduate programme in mental health nursing (see Te Ao Māramatanga: New Zealand College of Mental Health Nurses' mental health nursing standards of practice) and preferably be at a proficient level in a Professional Development and Recognition Programme.

¹⁴⁷ Section 71(2) of the Mental Health Act requires that, except in an emergency, 'seclusion shall be used only with the authority of the responsible clinician' and that 'In an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician.'

8.5.5 Ending seclusion

Each seclusion event should be for the shortest time possible, and a maximum of 2 hours (unless a decision is made to continue). If staff have addressed the reasons for seclusion, and seclusion is no longer needed, a decision to end seclusion must be taken by 2 suitably qualified clinicians following an assessment of the person. The responsible clinician must be informed of the decision to end seclusion.

If the person is asleep while in seclusion, we strongly recommend that staff consider whether seclusion is still necessary. It is not necessary to wake the person to end the episode of seclusion.

An episode of seclusion is deemed to have ended if the person leaves the conditions of seclusion without expectation of return, and in any case is deemed to have ended if the person has been out of seclusion for more than 1 hour.

8.5.6 Reintegration

A planned and gradual process of reintegration into the ward should occur, particularly after an extended period in seclusion. This can also provide an evaluation period to inform the ending of a seclusion episode.

It is important that people feel safe during the reintegration process. Reintegration should start with the door opening and move to integration during times of least stress and disruption, with increasing amounts of time out of seclusion. Clinicians should consider involving family/whānau in supporting tāngata whaiora in the integration process.

Staff should consider an assessment of reintegration attempts when deciding whether to continue seclusion. When a person is able to spend increasing amounts of time out of seclusion, staff should look to ending the seclusion event.

If a person spends longer than an hour out of seclusion, the seclusion episode is deemed to have ended. Therefore, if the person has been out of seclusion for longer than an hour, and 2 suitably qualified clinicians determine that a further period of seclusion is required, they must record this as a separate seclusion event.

Staff should provide a person with the opportunity to reintegrate as soon as they are ready and for as long as they can manage. Tāngata whaiora may have specified their preferences for how they are supported to reintegrate into the unit in their advance directive. Staff should follow advance directives where they exist.

8.5.7 Extended periods of seclusion

For the purposes of these guidelines, an extended period of seclusion is defined as when the person's cumulative hours spent in seclusion exceed 24 hours over the course of one admission, within a 4-week period. Staff must inform the DAMHS and a local district inspector when this occurs.

We expect that, in this situation, a case review should occur so that staff can consider alternatives to the continued use of seclusion. It is important that the person's multidisciplinary team, senior clinical leadership for the service, cultural advisors and independent advocates are present at the case review. The person's family/whānau should also be included if the person wants them to be involved. Case reviews should occur in addition to daily reviews by the person's responsible clinician and multidisciplinary team members.

If efforts to end seclusion are not successful following a case review, we strongly recommend that services request an independent external review to consider alternatives to the continued use of seclusion.

Where people undergo extended periods of seclusion, staff should consider their ability to exercise and access meaningful activity, including through access to an outdoor area if this is safe. Services must also consider the impact of an extended period of seclusion on a person's right to company.

8.6 Specific observation, engagement and assessment requirements

8.6.1 Continuous observation

Observation of people in seclusion must be continuous and by a registered nurse or another suitably trained staff member delegated by a registered nurse.¹⁴⁸ We do not recommend short-span timed checks (for example, checks at 5- or 10-minute intervals), because of their high risk: the person may engage in harmful behaviour during known gaps in observation.

Observations must include practical measures to ensure that the person is not in physical distress at the time they are being observed. This will require actual physical observation and interaction with the person; video surveillance is not an acceptable form of observation. Criterion 6.2.4(g) of Ngā Paerewa states that documentation of an episode of restraint should include observations and monitoring of the person during the restraint.

Staff should follow the individual preferences of tāngata whaiora in relation to the staff member carrying out the observation where practically possible. For example, people may have a preference regarding the culture or gender of their observer. Staff should seek out and record individual preferences in the person's advance directive (or other individualised plan) and should consider them in the context of people's trauma history. Staff must ensure people's privacy when they are using the toilet or shower.

¹⁴⁸ Nursing Council of New Zealand. 2012. *Guideline: delegation of care by a registered nurse to a health care assistant*. Wellington: Nursing Council of New Zealand.

The New Zealand Directors of Mental Health Nursing have issued a position statement on enhanced engagement and observations. The following points from that statement are relevant in the context of seclusion.

- It is important that staff view observations as an opportunity for therapeutic engagement, rather than an administrative task.
- The model of care should inform enhanced engagement and observations.
- There must be a clear rationale for levels of enhanced engagement and observation that addresses the following:
 - location of patients within the inpatient facility and expectations of the type of assessment occurring: for example, aspects of physical health status, colour and respiratory function. These observations could be enhanced by technologies (for example, for pulse checking) and could reduce the potential for error, especially in night observations
 - preventing patients from harming themselves
 - preventing patients from harming others.¹⁴⁹

8.6.2 Engagement

It is not enough to simply observe people in seclusion. We also expect that staff will intentionally engage with people in seclusion. Engagement can include eye contact, conversation or activities.

An exception to this may be where the person is sleeping, and observation is sufficient to confirm signs of life and establish that the person is not in physical distress. Confirming signs of life in this context means visibly seeing the chest moving, hearing breathing or observing snoring. If these signs are not present, staff will need to wake the person. If a person in seclusion is asleep and signs of life are present, staff should consider whether seclusion is still needed. Staff should also respect that some people prefer to rest and will not wish to engage.

Engagement and observation is about meeting enhanced needs. Observation is only one aspect of caring for people during high periods of distress. All staff are expected to engage people in meaningful activities and provide psychological support.
Hawke's Bay, observation and engagement policy, 2013

Engagement plays an important role in creating a healing environment and promoting recovery. Engagement must occur in a safe and supportive way.

Staff engaging with people in seclusion should incorporate cultural practices to support the wairua of those in seclusion as appropriate, and record this in the person's notes. Where possible, kaimahi Māori should engage with and assess the needs of Māori in seclusion.

People's need for engagement, and the type of engagement they need, will differ for each person. Staff should consider each person's trauma history and the reason for their current seclusion episode before engaging with them.

¹⁴⁹ New Zealand Directors of Mental Health Nursing. 2015. *Enhanced Engagement and Observation: A paper to inform the development of engagement and observation policies and procedures in inpatient units*. Unpublished.

8.6.3 Mental and physical wellbeing assessment

A suitably qualified clinician must enter the room at least once every 2 hours to assess the physical wellbeing of a person in seclusion unless there is a risk of harm to staff or others. It is important to monitor and assess a person's physical health during a period of seclusion, as discussed in section 8.3. If a clinician's attempt to enter the room is unsuccessful, the clinician must record the reason for this on an observations form.

In addition to assessing the person's physical wellbeing, the clinician should assess the person's mood and behaviour at this time. The assessment should include physical observations, including level of consciousness, breathing, colour and vital signs.

Each entry to the seclusion room is an opportunity to assess whether the person still requires seclusion.

8.6.4 Clinical assessment

Staff must provide and record an ongoing programme of care and assessment for people in seclusion, over the period of their shift. This should include:

- observations and care as described above
- documented clinical consultation with the responsible clinician
- communication of all care requirements, both verbally and via the person's plan, to staff on the following shift; for example:
 - food/fluid intake
 - personal care/hygiene/toileting arrangements
 - medication requirements
 - blood pressure, pulse and oxygen statistics
 - exercise/physiotherapy
 - visitors (chaplain, advocates, family/whānau, cultural support workers, peer support workers).

Wherever practicable, staff should provide care in accordance with the preferences of the person in seclusion. They may need to give consideration to the person's culture or gender. These preferences can be outlined in the person's advance directive (or other individualised plan), and they should be considered in the context of their trauma history.

A suitably qualified clinician must perform a clinical assessment of the person in seclusion once per shift, including a mental state examination, and document this.

9 Quality review of restraint and seclusion

9.1 Debrief

Ngā Paerewa criterion 6.2.5 states: 'A person-centred debrief shall follow every episode of emergency restraint. Participation in this debrief shall be determined by the person when they feel ready'.

A staff debrief should also follow every episode of emergency restraint. This is supported by section 14.7.3 of the *Guidelines to the Mental Health Act*, which states: 'All restraint events and episodes must be reviewed, and the staff involved must detail the circumstances leading up to the restraint and explain the rationale for restraining the person'.¹⁵⁰

Services should seek people's preference as to who they would like to do the debrief with. They should offer tāngata whaiora Māori a cultural advisor or kaimahi Māori to conduct their debrief. People may also wish to include a lived experience worker or peer support worker, independent advocate or family/whānau in the debrief process.

The debriefing process may help restore trust and therapeutic relationships following a restraint event. This may benefit not only the person who was secluded or restrained, but also the staff involved in the seclusion or restraint and those who witnessed the event.

It may also be appropriate to offer a debrief to other tāngata whaiora and staff who witnessed a restraint episode. This process may offer staff a safe space to raise concerns about the use of seclusion or restraint, including possible misuse or inappropriate practice.

A restorative practice approach may be an effective and appropriate method of debriefing after a restraint event (see section 4.9 above). Hohourongo (restoring peace and balance) is a process tāngata whaiora Māori may want to engage in that upholds tikanga Māori.¹⁵¹

Te Pou's *Debriefing following seclusion and restraint: A summary of relevant literature*¹⁵² includes helpful information for service providers on the content and process of a debrief.

¹⁵⁰ Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health, p.130.

¹⁵¹ See for example www.psychology.org.nz/journal-archive/NZJP-Vol372-2008-3-Rata.pdf (accessed 31 March 2023).

¹⁵² Te Pou o te Whakaaro Nui. 2014. *Debriefing Following Seclusion and Restraint: A summary of relevant literature*. Auckland: Te Pou o te Whakaaro Nui.

The HQSC has also developed a set of principles that mental health and addiction services can use to engage with people and their whānau following an adverse event. Staff will find these principles helpful when they are participating in a person-centred debrief of a seclusion or restraint event, and when they are reviewing any adverse events that occur during an episode of seclusion or restraint. The principles, along with other resources for reviewing adverse events, are available on HQSC's website.¹⁵³

Staff should remind tāngata whaiora of their right to complain or provide feedback about the care they have received. If a person wishes to make a complaint or provide feedback, staff should assist them to do so and provide them with the relevant information in an appropriate way.

People can make complaints through the health service directly or via district inspectors. Services should also remind people of the free Health and Disability Commissioner Advocacy service, which can support people to lay a complaint.

9.2 Evaluation

Ngā Paerewa criterion 6.2.7 requires that each episode of restraint shall be evaluated, and that service providers shall consider:

- time intervals between the debrief process and evaluation process (to be determined by the nature and risk of restraint or seclusion being used)
- the type of restraint used
- whether the person's care or support plan, and advance directives or preferences (where in place) were followed
- the impact the restraint had on the person (to inform changes to the person's care or support plan resulting from the person-centred and whānau-centred approach/reflections debrief)
- the impact the restraint had on others (for example, health care and support workers, whānau, and other people)
- the duration of the restraint episode and whether this was the least amount of time required
- evidence that other de-escalation options were explored
- whether appropriate advocacy or support was provided or facilitated
- whether the observations and monitoring were adequate and maintained the safety of the person
- future options to avoid the use of restraint
- suggested changes or additions to de-escalation education for health care and support workers
- the outcomes of the person-centred debrief
- review or modification required to the person's care or support plan in collaboration with the person and whānau

¹⁵³ www.hqsc.govt.nz/resources/resource-library/principles-for-engaging-consumers-and-whanau-in-mental-health-and-addiction-adverse-event-reviews/ (accessed 31 March 2023).

- a review of health care and support workers' requirements (for example, whether there was adequate senior staffing, whether there were patterns in staffing that indicated a specific health care and support workers' issue, and whether health care and support workers were culturally competent).

Ngā Paerewa criterion 6.4.6 requires that service providers evaluate each seclusion event as soon as reasonably possible after the event, and these guidelines recommend that this occurs within 7 days. The evaluation must be undertaken by registered health professionals from at least 2 different disciplines and (where available) a Māori or Pacific cultural advisor and lived experience advisor (Ngā Paerewa criterion 6.4.6). The evaluation shall consider:

- whether the person's care or support plan and advance directives and preferences (where in place) were followed
- the impact the seclusion had on the person, other people using the service, and health care and support workers
- the duration of the seclusion event and whether this was the least amount of time required
- what alternative interventions were considered, why any were not used, and therefore why seclusion was the option of last resort
- whether appropriate advocacy or support was sought, provided, or facilitated
- whether the observations and monitoring were adequate and maintained the safety of the person
- future options to eliminate seclusion
- any suggested changes or additions to seclusion education for health care and support workers
- the outcomes of the person- and whānau-centred debrief
- review or modification required to the person's care or support plan in collaboration with the person.

Health care and support workers should have the opportunity to be involved in a wider debrief or discussion following significant incidents. This is to support their wellbeing, maximise learning from the evaluation of the seclusion event and ensure safety for all (Ngā Paerewa criterion 6.4.6).

9.3 Monitoring and recording seclusion and restraint

Monitoring of seclusion and restraint must acknowledge people's cultural, physical, psychological and psychosocial needs and must address wairuatanga (Ngā Paerewa criterion 6.2.3).

Services must keep a register of seclusion and restraint, and record the duration and episode of each episode of seclusion in that register (sections 71 and 129(1)(b) of the Mental Health Act). These guidelines also require services to document each episode of

restraint in the restraint and seclusion register and in people's clinical records. Episodes of seclusion and restraint must be recorded in sufficient detail to provide an accurate rationale for their use, duration and outcome. To conform with Ngā Paerewa criterion 6.2.4, the restraint and seclusion register should include:

- the type of restraint used (for episodes of restraint)
- details of the reasons for initiating restraint or seclusion
- the decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered prior to the use of restraint or seclusion
- if required, details of any advocacy and support offered, provided, or facilitated (eg, whānau, friends, Māori services, Pacific services, interpreter, personal or family advisor, or independent advocate)
- the outcome of the restraint or seclusion episode
- any impact, injury, and trauma on the person as a result of the use of restraint or seclusion
- observations and monitoring of the person during restraint or seclusion
- comments resulting from the evaluation of the restraint or seclusion
- a record of the person-centred debrief, including a debrief by someone with lived experience (if appropriate and agreed to by the person). This shall document any support offered after the restraint or seclusion, particularly where trauma has occurred (eg, psychological or cultural trauma).

It would also be useful for the restraint and seclusion register to record details about the staff involved in the seclusion or restraint episode such as their designation and relevant training.

As mentioned above, seclusion must only occur in a room or other area approved by the DAMHS. However, if an individual is placed in a defined space on their own from which they cannot freely exit, whether or not it is a designated seclusion room, the service must record and report this as seclusion. The exception is where a person's bedroom door in a Regional Forensic Mental Health Service is locked overnight, for the purposes of safety; this is considered a form of environmental restraint (see section 7.2.3 above).

As for other aspects of the Mental Health Act, we expect that district inspectors will monitor whether services have complied with the procedures in these guidelines by reviewing the restraint and seclusion register and other accompanying documents.

Service providers must provide seclusion data to their governing bodies on a monthly basis (Ngā Paerewa criterion 6.4.2).

9.4 Reviewing restraint and seclusion

Ngā Paerewa criterion 6.3.1 requires that service providers conduct comprehensive reviews at least 6-monthly of all restraint practices used by the service, including:

- that a human rights-based approach underpins the review process (see section 2.2 above)
- the extent of restraint, the types of restraint being used, and any trends
- how the service is mitigating and managing the risk to people and health care and support workers
- progress towards eliminating restraint and development of alternatives to using restraint
- adverse outcomes
- compliance with policies and procedures, and whether changes are required
- whether the approved restraint is necessary; safe; of an appropriate duration; and in accordance with the person's health care, support workers' feedback, and current evidence-based best practice
- if the person's care or support plans identified alternative techniques to restraint
- the person's perspectives and those of their whānau are documented as part of the comprehensive review
- consideration of the role of whānau at the onset and evaluation of every instance of restraint
- data collection and analysis (including identifying changes to care or support plans and documenting and analysing learnings from each event)
- service provider initiatives and approaches supporting a restraint-free environment.

Services should report the outcome of such reviews to the governance body.

Ngā Paerewa criterion 6.4.7 requires that service providers conduct comprehensive reviews at least 6-monthly of all seclusion events, to determine how the service is working towards maintaining zero seclusion, and to determine:

- that a human rights-based approach underpins the review process (see section 2.2 above)
- the number of people secluded, the number of episodes of seclusion, their duration, demographics and any trends
- how the service is mitigating and managing the risk to the person, other people in the environment, and health care and support workers
- progress towards eliminating seclusion, and development of the many alternatives to using seclusion
- adverse outcomes
- compliance with policies and procedures, and whether changes are required

- whether there are additional education or training needs, or changes required to existing seclusion-elimination education
- service provider initiatives, and approaches that support and will achieve zero seclusion.

Services should report the outcome of such reviews to the governance body.

9.5 Reporting to Manatū Hauora

The Director of Mental Health requires the DAMHS to submit restraint data on a quarterly basis. This currently includes data on the number of people restrained and the number of restraint events, alongside the ethnicity, gender and age of the people restrained and the type of restraint used.

In addition to this, mental health services must report to Manatū Hauora on the use of seclusion via the Programme for the Integration of Mental Health Data (PRIMHD) for monitoring purposes.

9.6 Complaints

Upholding a person's right to complain is particularly important in the context of seclusion and restraint, because these practices override people's autonomy and reinforce the power imbalance between service providers and people receiving treatment. Ensuring that people feel safe and empowered to speak up when they have concerns about these practices is critical for their wellbeing and helps to build and restore trust. It also contributes to quality improvement and services' ability to monitor progress over time.

Subsection 1.8 of Ngā Paerewa relates to people's right to complain. It sets out the outcomes sought and the criteria for service providers. It requires them to:

- understand, respect and uphold the right of tāngata whaiora to make a complaint
- inform tāngata whaiora about the complaints process and ensure they have easy access to a fair and responsive complaints process that is sensitive to, and respects, their values and beliefs
- address and resolve tāngata whaiora's complaints in accordance with the Code of Rights
- inform tāngata whaiora of the findings of their complaint
- ensure that the Code of Rights and the complaints process work equitably for Māori.

In addition, anyone who is subject to the Mental Health Act can contact a district inspector, who is empowered to investigate complaints of breaches of the rights of patients under section 75 of the Mental Health Act.

Glossary

Term	Definition
Child/tamariki	A person under the age of 14 years, as defined in section 2(2) of the Oranga Tamariki Act 1989.
Code of Rights	Code of Health and Disability Services Consumers' Rights.
Director of Area Mental Health Services (DAMHS)	A person appointed by the Director-General of Health under section 92 of the Mental Health Act who is responsible for the day-to-day operation of the Mental Health Act in their appointed area. ¹⁵⁴
Director of Mental Health	A person appointed under section 91 of the Mental Health Act who is responsible for the general administration of the Mental Health Act.
District inspector	A lawyer appointed under section 94 of the Mental Health Act by the Minister of Health to protect the rights of people receiving treatment under the Act. District inspectors are independent from the Manatū Hauora and from health and disability services. ¹⁵⁵
Environmental restraint	Where a service provider intentionally restricts a person's normal access to their environment; for example, where a person's normal access to their environment is intentionally restricted by locking or blocking doors.
<i>He Ara Oranga</i>	<i>He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.</i> ¹⁵⁶
Least restrictive practices	Under section 0.3 of Ngā Paerewa, 'practices that enhance a [tangata whaiora's] autonomy and respect their rights, individual worth, dignity, and privacy. Restrictive practices make someone do something they do not want to do or stop someone doing something they want to do'.

¹⁵⁴ Ministry of Health. 2022. *Guidelines for the Role and Function of Statutory Officers: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

¹⁵⁵ www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/mental-health-compulsory-assessment-and-treatment-act-1992/mental-health-district-inspectors (accessed 31 March 2023).

¹⁵⁶ Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction.

Lived experience	Under section 0.3 of Ngā Paerewa, 'Expertise, skills, and knowledge gained through direct, first-hand receipt of care of support services'.
Lived experience advisor	A person with a personal lived experience of mental health or addiction challenges who is employed to provide support, advocacy and advice within a service. Other job titles that bring a lived experience perspective are 'lived experience worker' and 'peer support worker'. Te Pou states that people in these roles are 'trained and employed in specific and identified lived experience roles to support others and inform and lead policy, process and service development using our experience, shared values, competencies, and approaches [... and] may be employed anywhere in mental health, addiction, health, and social sectors, where people who are experiencing mental health and addiction needs seek support'. ¹⁵⁷ See also 'Peer'.
Guidelines to the Mental Health Act	<i>Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992</i> ¹⁵⁸
Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act)	An Act that provides a legal framework for those experiencing a mental illness who require compulsory psychiatric assessment and treatment. The Act defines the rights of patients and proposed patients, to provide protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of people ex mental disorder.
Patient or proposed patient	These terms have the meanings set out in section 2 of the Mental Health Act.
Peer	A person who has had similar experience to another person or people, such as lived experience of mental distress or addiction that has had a significant impact on a person's life. ¹⁵⁹
Personal restraint	Where a service provider uses their own body to intentionally limit a person's movement. In other jurisdictions, personal restraint is called 'physical restraint'.

¹⁵⁷ Te Pou o te Whakaaro Nui. 2020. *Mental Health & Addiction Consumer, Peer Support & Lived Experience: Workforce development strategy 2020 to 2025*. Auckland: Te Pou o te Whakaaro Nui.

¹⁵⁸ Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

¹⁵⁹ As defined in Swanson C, Caldwell V, Shearer R. 2014. *Competencies for the Mental Health and Addiction Service User, Consumer and Peer Workforce*. Auckland: Te Pou o te Whakaaro Nui.

Physical restraint	Where a service provider uses equipment, devices or furniture that limits a person’s normal freedom of movement. In other jurisdictions, physical restraint is called ‘mechanical restraint’.
Programme for the Integration of Mental Health Data (PRIMHD)	Manatū Hauora’s single national mental health and addiction information collection of service activity and outcomes data for health consumers.
Responsible clinician	Under section 2 of the Mental Health Act, ‘in relation to a patient, ... the clinician in charge of the treatment of that patient’.
Restraint	Under section 0.3 of Ngā Paerewa, ‘The use of any intervention by a service provider that limits a person’s normal freedom of movement. Where restraint is consented to by a third party, it is always restraint’. See also environmental restraint, personal restraint and physical restraint.
Safe Practice and Effective Communication (SPEC)	A national training course that supports best and least restrictive practice in mental health inpatient units. ¹⁶⁰
Seclusion	Under section 0.3 of Ngā Paerewa, ‘a type of restraint where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit’.
Suitably qualified clinician	A suitably qualified clinician is either a registered nurse or a medical practitioner. The registered nurse must have mental health training and experience (as has been defined for the completion of certificates under section 8B of the Mental Health Act) and must have completed an undergraduate or postgraduate programme in mental health nursing (see Te Ao Māramatanga: New Zealand College of Mental Health Nurses’ mental health nursing standards of practice) and preferably be at a proficient level in a Professional Development and Recognition Programme.
Tangata whaiora (singular), tāngata whaiora (plural)	As defined in Te Reo Hāpai The Language of Enrichment (a Māori language glossary for use in the mental health, addiction and disability sectors), a person/people with wellness, ¹⁶¹ sometimes used as 3 words: tangata/tāngata whai ora.

¹⁶⁰ www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/safe-practice-effective-communication (accessed 29 March 2023).

¹⁶¹ www.tereohapai.nz/ (accessed 31 March 2023).

<p>United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) and the Optional Protocol</p>	<p>A convention that prohibits torture and other acts of cruel, inhuman, or degrading treatment or punishment and provides reporting, inquiry, and complaints procedures. The Optional Protocol to the CAT provides for an independent national preventive mechanism. For more information, see www.justice.govt.nz/.</p>
<p>United Nations Convention on the Elimination of all forms of Racial Discrimination</p>	<p>The main international human rights treaty dealing with racial discrimination. It focuses on matters such as addressing race-based discrimination or violence and condemning ideas of racial superiority or hatred. It requires countries to protect human rights in an equitable way, including rights to health and adequate housing, and freedom of expression. For more information, see www.justice.govt.nz/.</p>
<p>United Nations Convention on the Rights of the Child</p>	<p>A comprehensive human rights treaty that enshrines specific children's rights in international law. More information about UNCROC is available on the Office of the Children's Commissioner's website.¹⁶²</p>
<p>United Nations Convention on the Rights of Persons with Disabilities</p>	<p>An international human rights treaty that sets out what is required to implement existing human rights as they relate to disabled people. More information is available on the Office for Disability Issues website.¹⁶³</p>
<p>United Nations Declaration on the Rights of Indigenous Peoples</p>	<p>A comprehensive international human rights document on the rights of indigenous peoples that covers a broad range of rights and freedoms, including the right to self-determination, culture and identity and rights to education, economic development, religious customs, health and language. More information is available on Te Puni Kōkiri's website.¹⁶⁴</p>
<p>Young person (or young people), rangatahi</p>	<p>Under the Mental Health Act, a person under the age of 17.</p>

¹⁶² www.occ.org.nz/rights/ (accessed 31 March 2023).

¹⁶³ www.odi.govt.nz/united-nations-convention-on-the-rights-of-persons-with-disabilities/about-the-convention/ (accessed 31 March 2023).

¹⁶⁴ www.tpk.govt.nz/en/a-matou-whakaarotau/te-ao-maori/un-declaration-on-the-rights-of-indigenous-peoples/ (accessed 31 March 2023).

Appendix A: Legislation specifically related to restraint

Mental Health Act

The Mental Health Act sets out specific powers to detain patients or proposed patients and also permits the use of force in certain circumstances under section 122B.

122B Use of force

- (1) A person exercising a power specified in subsection (2) may, if he or she is exercising the power in an emergency, use such force as is reasonably necessary in the circumstances.
- (2) The powers are—
 - (a) a power to take or retake a person, proposed patient, or patient in any of **sections 32(1), 38(4)(d), 40(2), 41(4), 41(5), 41(6), 50(4), 51(3), 53, 109(1), 109(4), 110C(2), 111(2), or 113A:**
 - (b) a power to detain a person, proposed patient, or patient in any of **sections 41(3), 41(4), 41(5), 109(4), 110C(2), 111(2), or 113:**
 - (c) a power to enter premises in either of **sections 41(2) or 110C(1).**
- (2A) A person permitted to restrain a transported special patient or use any other force under **section 53A** may use such force as is reasonably necessary in the circumstances.
- (3) A person treating a patient to whom **section 58** or **section 59** applies may use such force as is reasonably necessary in the circumstances.
- (4) If force has been used under this section,—
 - (a) the circumstances in which the force was used must be recorded as soon as practicable; and
 - (b) a copy of the record must be given to the DAMHS as soon as practicable.

Guidance on the use of force under the Mental Health Act is provided in the *Guidelines to the Mental Health Act*.

Crimes Act

In addition, there are a number of relevant sections in the Crimes Act 1961, including sections 41(1), 48(1) and 151, which are as follows.

Section 41 Prevention of suicide or certain offences

- (1) Everyone is justified in using such force as may be reasonable and necessary in order to prevent the commission of suicide, or the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which he or she believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence.

Section 48 Self-defence and defence of another

- (1) Everyone is justified in using, in defence of himself or herself or another, such force as, in the circumstances as he or she believes them to be, it is reasonable to use.

Section 151 Duty to provide necessities and protect from injury

Everyone who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessities is under a legal duty—

- (a) to provide that person with necessities; and
- (b) to take reasonable steps to protect that person from injury.

Section 157 Duty to avoid omissions dangerous to life

Everyone who undertakes to do any act the omission to do which is or may be dangerous to life is under a legal duty to do that act.

Appendix B: Recommended guidelines and other documents

Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction.

Huriwai T, Baker M. 2016. *Manaaki: Mana enhancing and mana protecting practice*. Wellington: Te Rau Matatini.

Māori Advisory Group. 2020. *Mental Health and Addiction Quality Improvement Programme: Tools and resources provided by the group as at 2018*. Wellington: Health Quality & Safety Commission.

Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington. Ministry of Health.

Ministry of Health. 2022. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington. Ministry of Health.

Shalev S. 2017. *Thinking outside the Box? A Review of Seclusion and Restraint Practices in New Zealand*. Wellington: Human Rights Commission.

Shalev S. 2020. *Time for a Paradigm Shift: A Follow Up Review of Seclusion and Restraint Practices in New Zealand*. Wellington: Human Rights Commission.