NZNO Mental Health Nurses Section
Newsletter
June 2023

Touching a nerve

The vexed issues of violence in Mental Health Inpatient Units – and responses to it – have been in the spotlight this month. An NZNO media release, requested by the Mental Health Nurses Section to highlight the ongoing problem of assaults on Nurses, attracted widespread attention – with coverage by RNZ (here and here) which also appeared on Newshub and in the *NZ Herald*. We were pleased that these news outlets reported the link which we made between violence and unsafe staffing levels.

Our media release followed a report, first published in the *Otago Daily Times*, about a Mental Health Nurse in Invercargill who was punched in the eye by a health consumer, and repeatedly in the side of her head. The consumer then bit the Nurse's arm so hard it pierced her skin through her clothes. In convicting the offender, Judge Catriona Doyle handed her a suspended sentence "to protect her mana and her dignity."

Our media release touched a nerve because appalling stories like these are all too common. The MHNS Committee has obtained a response to an Official Information Act request showing that there were 197 recorded assaults on Mental Health Nurses and Support Workers in the Auckland Metropolitan District alone in the year to 27 November 2022. 192 of them occurred in inpatient settings.

In an environment like this, it's easy to feel that the future of Mental Health Nursing is dim. But working in collaboration with Te Ao Māramatanga NZ College of Mental Health Nurses and the Mental Health Directors of Nursing, MHNS is also boldly charting a positive vision for our profession's future.

Over the last two years, this collaborative has been at work revising and updating the 2006 document *Mental Health Nursing and its Future: A Discussion Framework*. The resulting *Destination 2030 – Future of Mental Health, Addiction and Disability Nursing in Aotearoa* consists of nine papers, covering Standards of Practice, Māori Mental Health, Addiction and Disability Nursing, Leadership, Education and workforce development for Registered Nurses, Professional/clinical supervision and cultural and/or kaupapa Māori supervision, Recruitment, Retention, Skill mix and the role of Nurse Practitioners. We are excited to be almost at the point of sharing *Destination 2030* with the sector and seeking your feedback.

Finally, in place of our regular feature article, this issue of the *MHNS Newsletter* contains the feedback which MHNS provided to the Ministry of Health Manatū Hauora on their draft

Guidelines for Reducing and Eliminating Seclusion and Restraint. We commented on perspectives which were missing from the draft Guidelines, including an acknowledgement that sometimes seclusion is used to help maintain the dignity and mana of a service user who may be engaging in behaviour which, later, they may wholly regret. We recommended that the guidelines include greater consideration of the needs of whānau, staff and peers and a more balanced approach to safety versus therapeutic value.

Although we are disappointed that our feedback was ignored by the Ministry in their final document, published in April, we are determined to continue advocating for practising Mental Health Nurses and the people we care for – whether in the media, in Ministry consultations or in other available forums.

We hope you find something of value in the following pages. If so, do feel free to forward it on, and maybe add a suggestion that your NZNO Mental Health Nursing colleagues join the Section as well.

Introducing Committee members Joy Neilson & Debbie Watson

Joy Neilson

Ko Takitimu te waka
Ko Tararua nga maunga
Ko Raumahanga te awa
Ko Wairarapa te moana
Ko Ngati Kahungunu ki Wairarapa te iwi
Ko Ngati Moe te hapu
Ko Papawai toku marae
Ko Rangitakiwaho toku tipuna
Ko Alex toku papa
Ko Kuia toku mama.

I was born and live in South Auckland. I am mother to five adult tamariki and nana to seven mokopuna. I have worked in mental health for 29 years, either in acute inpatient or in the crisis team in the community. I have held several leadership roles within those

services. I am a PSA delegate in my work place. But I am also a member of the NZNO and look forward to serving as a NZNO member on the Mental Health Committee.

Debbie Watson

I have seven years experience as a RN across various settings in acute and community general nursing, including three years as CAMHS Nurse. From 2009 until now, I have been a Nurse Educator at SIT in Invercargill. During this time, I also maintained my practice as a RN Casual Inpatient MH and Casual CAFS Nurse for a period of time (but not currently). For three years as a Programme Manager at the School of Nursing at SIT I was part of committees as such:

- SDHB Future Nursing Workforce Strategic Planning Committee
- SIT Nursing Advisory Committee
- SIT Teaching & Learning Board of Studies committee

The MHNS Committee is thrilled to welcome our two new members and can now report that we have a full Committee, which comprises in addition Helen Garrick (Chairperson), Jennie Rae (Treasurer), Grant Brookes (Secretary), Fiona McNair (Facebook Administrator) and Anne Brinkman (Professional Nurse Advisor).

Committee news

The MHNS Committee has met twice since our last newsletter in December. At our March meeting, the focus was very much on our imminent educational Forum and Biennial General Meeting to be held the following day (see separate news item, below).

The MHNS Committee meeting this month discussed at length the troubling issue of workplace violence. As well as deciding to request the NZNO media release, mentioned above, the Committee also agreed to write to the Chief Victims Advisor at the Ministry of Justice to highlight the issue of victims' rights for Mental Health Nurses who are assaulted at work and to write to the NZNO Board and CEO about the need to continue whole-of-organisation work on this issue.

The Committee also heard that NZNO Professional Nurse Advisors are finding a new

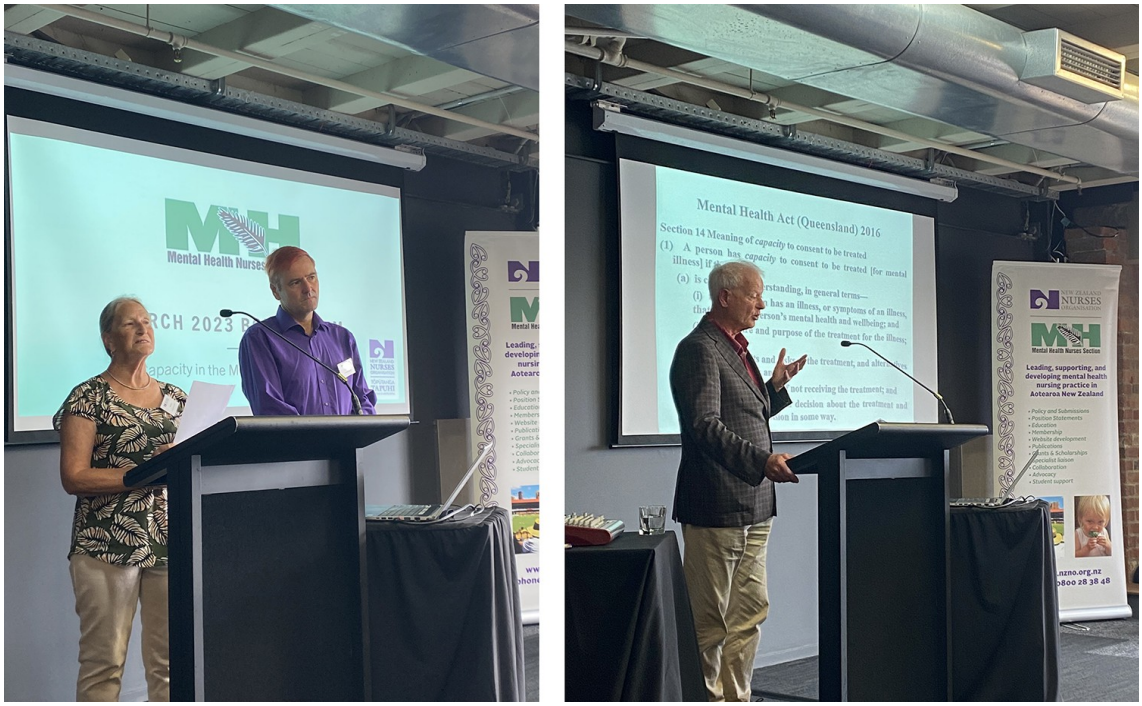
willingness by employers to acknowledge staffing shortages. These shortages are not being resolved through the Care Capacity Demand Management Programme. The large amount of time being spent on CCDM work, with little benefit to show, is leading to a re-evaluation of NZNO's engagement in the Programme.

The current review of the NZNO Constitution also received attention at our June meeting. This review was initiated in 2020, after a remit from MHNS and the NZNO Cancer Nurses College was passed by members, calling for a full, independent review. An NZNO member consultation opened on 2 June, asking members for their views about the key functions of NZNO and about whether our current member structures give effect to Te Tiriti o Waitangi and embed democratic processes for members that can work in a bicultural environment. The Committee encourages all of our MHNS members to respond before the closing date of 7 July. For more information, a copy of CEO Paul Goulter's recent email on the Constitutional Review is available here.

MHNS Forum a success!

After years of frustrating postponements due to Covid-19, the long-awaited MHNS Forum and BGM finally went ahead in March. Gathering in person in Wellington and online via Zoom, Forum participants heard from:

- Professor John Dawson – Otago University. "The reasons why capacity principles might be included in mental health law and the potential implications for nurses"
- Erika Butters – Protecting Vulnerable Adults Trust. "Principles of supported decision making and the rights-based approach"
- Teresa O'Connor, Past Editor *Kaitiaki, Nursing New Zealand*. "Political action: A necessity for the survival of mental health nursing"



1. MHNS Treasurer Jennie Rae & Secretary Grant Brookes. 2. Prof John Dawson

1. Erika Butters 2. Teresa O'Connor

Feedback about the Forum has been overwhelmingly positive. In a post-event survey completed by half of Forum participants, 90 percent of respondents rated the Forum as “Good” or better, with 85 percent saying it was “Very Good” or “Excellent”. There were also very useful suggestions on how we can make the next one even better, including some interesting topic suggestions.

Changes to the MHNS Newsletter

After a couple of years as editor of the MHNS Newsletter, it's time for Grant Brookes to move on. His responsibilities on the Board of Directors and in his new roles as MHNS Secretary and Chair of NZNO Greater Wellington Regional Council sadly leave too little time to continue. The MHNS Committee has plans in place to keep up communication with MHNS members, however. Look out for a new format in your inboxes this year.

MHNS feedback on draft *Guidelines for Reducing and Eliminating Seclusion and Restraint*

The Mental Health Nurses Section of the New Zealand Nurses Organisation (MHNS) welcomes the opportunity to give feedback on the draft *Guidelines for Reducing and Eliminating Seclusion and Restraint*.

We support the purpose of the guidelines in reducing and eliminating seclusion and identifying best practice for use in mental health acute inpatient units.

The opening statement, "Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained", summarises the views of the nurses within our Section Committee and highlights the importance of maintaining dignity and mana. Our first point is that sometimes seclusion is used to help maintain the dignity and mana of a service user who may be engaging in behaviour which, later, they may wholly regret and then suffer humiliation and remorse/guilt because of this behaviour. Seclusion may be used in situations where all best practice methods have been tried unsuccessful and there is a need to assist the service user to protect their dignity.

The MHNS agrees with the statement in section 1.1 of the guidelines that there may be little therapeutic value in the use of seclusion and restraint for many service users, and harm may occur through these interventions. We also note that some service user behaviour may result in psychological trauma, physical injury, cultural harm, and damage to therapeutic relationships. This behaviour may involve serious harm to the service user, other service users in the environment, staff, and whānau. As an example, to illustrate this need to consider a wider picture, a member of the MHNS has recently provided an exemplar involving seclusion, drawn from their practice in an adult acute inpatient unit this month, through which we may analyse this statement. Our member advises that the exemplar contains features typical of a seclusion event in their unit.

> *A vulnerable young female in the main ward approached me reporting that she had been indecently assaulted by an older male service user. The male approached her from behind, she said, grabbed her and pressed his penis into her buttocks. This was not witnessed by staff. Both the perpetrator and the victim of the indecent assault were patients subject to compulsory assessment and treatment and both were of Samoan ethnicity. A Reportable Event was completed and the next of kin (mother) of the victim was informed. The mother was distressed and demanded that the incident be reported to Police. After consultation within the Health Care Team, Police were notified by staff as the victim was unwilling to lay a complaint herself. The Police responded shortly after, stating that they would attend the unit to take statements and consider prosecution and this did happen, a week and a half later.*
>
> *In the meantime, the perpetrator was firstly confronted over his behaviour. He denied the indecent assault. He was placed on a higher level of observation. The victim appeared fearful and over the succeeding period, she spent most of her time self-isolating in her bed space.*
>
> *Two days after the incident, the young female approached staff to say that the man had indecently assaulted her again, putting his hand down her top and groping her breast while she was in the television lounge. Despite the higher level of observation,*

this incident was also unwitnessed by staff. She expressed that she was now extremely uncomfortable being in the vicinity of the man. A decision was made to use environmental restraint, moving him to the smaller de-escalation area which is separated from the main ward by a locked door. The victim expressed relief and feelings of safety. The next of kin was again informed, and thanked staff for the course of action which had been taken.

The following day in the de-escalation area, the male approached a young Samoan Mental Health Support Worker silently from behind and punched him in the head. The male was then secluded.

After the seclusion was terminated, a person-centred debrief was conducted. The male denied punching the Mental Health Support Worker and denied touching the young woman. He said that he had been secluded for no reason, treated unfairly and that he now finds it harder to trust staff. He said that the seclusion re-triggered trauma he had experienced in prison, where he had served sentences for his many previous convictions for sexual and violence offences. His progress towards discharge has been delayed.

This exemplar demonstrates how different perspectives lead to different evaluations of the therapeutic benefit of seclusion and restraint. In this exemplar, the statement in section 1.1 of the draft guidelines reflects the perspective of the perpetrator. He expressed that it caused him psychological trauma (including re-triggering existing trauma) and it reduced trust and damaged therapeutic relationships. However, from the perspective of the victim, the restraint had significant therapeutic benefit, relieving distress, and allowing her to socialise safely again with her peers. It reduced psychological trauma (including re-triggering existing trauma from the indecent assault) and it improved therapeutic relationships, both with the person and her whānau.

As currently written, the statement in section 1.1 of the guidelines is not adequately supported by the evidence provided, failing to reflect significant perspectives. With no supporting evidence, the assertion is repeated in section 7 that, “it is now understood that seclusion has no known therapeutic value.” MHNS recommends that that these sections are rewritten. We recommend the inclusion of discussion about the balance of safety versus therapeutic value.

We agree that there should be a strong emphasis on respect for cultural identity in all areas of service provision.

The MHNS explored the issue of restraint and seclusion extensively with the Government Inquiry into Mental Health and Addiction team. We were disappointed that the distressing discussions on the dilemmas faced by mental health and addiction nurses in the provision of safe care in acute and forensic units was not addressed in the report. This report unfortunately did not cover the issue of maintaining safety for service users, staff and whānau.

The MHNS notes the inclusion of health and safety at work in these guidelines, but this section needs to be addressed more comprehensively. What are the recommendations for situations where the level of acuity is unsafe for staff and people using the service?

Section 1.3 introduces *Ngā Paerewa Health and Disability Services Standard* and endorses the philosophical shift “towards person-centred and whānau-centred health and disability services.” After announcing this shift, however, the remainder of the *Guidelines* is centred squarely on the individual tangata whaiora who is subject to restraint or seclusion. While there is consideration in section 5.3. of the role of family/whānau in the case of tamariki and rangatahi, whānau perspectives (much like staff perspectives) are largely absent elsewhere in the guidelines. As noted above, the perspective of peers using the service where restraint and seclusion take place are ignored entirely. MHNS recommends that the guidelines are revised to include greater consideration of the needs of whānau, staff and peers.

The MHNS agrees that the use of sedative medication may be a form of restraint, and this is not desirable. This approach has often been seen as an alternative to seclusion, but this would not be acceptable.

The MHNS agrees with all five principles for the use of seclusion and restraint as listed on page 13. We also agree with the six core strategies but do not consider that these are sufficient to address the level of violence occurring at times in inpatient settings. The effective ways to support people in distress and help avoid seclusion (as listed on page 14) are useful techniques but grossly inadequate for an angry, highly distressed and/or volatile service user who may be influenced by substances. The promotion of these techniques as prevention of seclusion may be unsafe in some circumstances. The use of seclusion "under urgency or in emergency situations once all other less restrictive options have been tried" creates a challenge, because urgent or emergency situations are usually rapidly developing, and there is unlikely to be time to experiment with 'least restrictive options' – especially where there is a high degree of risk to staff or other patients due to aggression by a patient – whatever the cause.

The MHNS agree with the focus on person-centred and trauma informed approaches as well as supported decision making (including advance directives) and note there is merit in ensuring all staff are trained in evidence-based interventions (Safewards, etc.) which have been demonstrated to reduce violence and aggression developing, but also in interventions (SPEC etc.) when a situation is unable to managed by other means. There needs to be support by the organisation for staff if a decision is made to use restraint/seclusion – not blame for failing to de-escalate a situation.

The MHNS looks forward to the implementation of these guidelines seeking to address the environmental issues that drive the use of restraint. These may include building design, noise levels, line of sight and other issues. Included in this leadership strategy should be the accountability for maintaining safe staffing levels including the skill mix of those involved in working in acute mental health units.

The *Guidelines* state (section 7.6.1, page 31): "Observation of people in seclusion must be continuous." This requirement is a new addition to the current guidelines. It is not practicable. There were 47,195 seclusion hours in adult mental health services in 2020, plus 23,825 hours in forensic services and 4,421 hours in forensic ID services [*2020 Regulatory Report, Office of the Director of Mental Health, and Addiction Services*]. There simply aren't enough staff available to provide constant observation on every person secluded, for the duration of the seclusion event. We are concerned that the guidelines reflect realistic practice recommendations – this is quite simply unrealistic within the environment created by current workforce shortages.

In addition, it conflicts directly with the position statement on enhanced engagement and observations issued by the New Zealand Directors of Mental Health Nursing, quoted on the same page, which states: "it is essential that levels of observations are determined by the needs of the person at risk and include consultation with them and their family/whānau". It also conflicts with *Ngā Paerewa Health and Disability Services Standard*, cited on the same page. *Ngā Paerewa* 6.2.2 states: "The frequency and extent of monitoring of people during restraint shall be determined by a registered health professional…" In case there was any doubt that this also applies to seclusion events, the definitions at *Ngā Paerewa* 0.3 confirm, "Seclusion [is] a form of restraint."

MHNS recommends that section 7.6.1 on observation is rewritten, removing the requirement for this to be continuous, to bring the guidelines into accordance with *Ngā Paerewa Health and Disability Services Standard* and the position statement from the Directors of Mental Health Nursing.

Thank you for the opportunity to provide feedback on these guidelines.

Helen Garrick

Chair

Mental Health Nurses Section of the New Zealand Nurses Organisation