MANATŪ HAUORA
MINISTRY OF HEALTH

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

2022

Contents

Introduction

Introduction to come

A note on the term 'patient'

Te Manatū Hauora Ministry of Health acknowledges that many people around Aotearoa New Zealand disagree with using the term 'patient' and 'proposed patient'. This view is understandable because such terms can reflect a stigmatisation of people who experience mental illness. This is such that they are at risk of being recognised and treated as people who are managed through medical treatment, rather than as individuals with choices and autonomy.

In these guidelines, we sometimes use the word 'patient' when referring to a specific part of the Mental Health (Compulsory Assessment and Treatment) Act 1992, in which 'patient' and 'proposed patient' have a specific legal meaning. These guidelines also use the terms 'person with lived experience', which is also used in Ngā Paerewa Health and Disability Services Standard, and 'tāngata whai ora'.

1. Purpose and context

The purpose of these guidelines is:

- to support the reduction and elimination of seclusion and restraint for people under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (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 acute inpatient units, in alignment with the specifications set out in Ngā Paerewa Health and Disability Services Standard NZS 8134:2021

> 'Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained'
> *Ngā Paerewa, Here Taratahi, Outcome 6*

These are not clinical guidelines. They are issued under section 130(a) of the Mental Health Act and intended to support the lawful application of the Act including section 71 'Right to company, and seclusion.' They are aimed at statutory officers and mental health professionals who use the provisions of the Mental Health Act. They will also assist auditors, advocates, and other agencies with an inspection role.

There is a process underway to repeal and replace the Mental Health Act. These guidelines will be reviewed once new mental health legislation has been developed. In this sense, they can be seen as interim guidelines.

This document should be read within the context of the following legislation, regulations, and guidelines.

- Care of Children Act 2004
- Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 and Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Health and Safety at Work Act 2015
- Health and Safety at Work (General Risk and Workplace Management) Regulations 2016
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (Ngā Paerewa)
- *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*[1] and *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*
- Health and Safety at Work Act 2015
- Health and Safety at Work (General Risk and Workplace Management) Regulations 2016
- Oranga Tamariki Act 1989
- Pae Ora (Healthy Futures) Act 2022
- Six core strategies for reducing seclusion and restraint-2nd edition, Te Pou

[1] Ministry of Health. 2020. Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health.

- The Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003 when being used in reference to care recipients.[2]

1.1. The commitment to reducing and eliminating seclusion and restraint

Te Manatū Hauora has a policy of reducing and eliminating seclusion and restraint in mental health services (*Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*[3]).

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

It is recognised that seclusion and restraint have no therapeutic benefit and can be harmful both for people experiencing mental distress and staff. The types of harm include psychological trauma (including re-triggering existing traumas), physical injury, cultural harm[4] and damage to therapeutic relationships.[5][6] The risk of physical injury during restraint appears to be higher for children and adolescents.[7] Seclusion and restraint also reduce autonomy, mana, and dignity.[8]

1.2. Upholding Te Tiriti o Waitangi and people's rights

1.2.1. Te Tiriti o Waitangi

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

Pae Ora (Healthy Futures) Act 2022 supports these obligations by requiring the health sector 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)).

[2] A Guide to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003: https://www.health.govt.nz/publication/guide-intellectual-disability-compulsory-care-and-rehabilitation-act-2003.
[3] Ministry of Health. 2012. Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017. Wellington: Ministry of Health.
[4] Cultural harm has been defined as "conduct that results in, or contributes to, the breakdown of the spiritual, moral, physical and emotional wellbeing of indigenous peoples or members of other groups sharing an ethnicity or cultural identity, and includes racist conduct." From https://royalsociety.org.nz/assets/Uploads/Code-of-Prof-Stds-and-Ethics-Revision-2.pdf, accessed 19 July 2022/
[5] Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J., & McSherry, B. M. (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.
[6] Kinner, S. A., Harvey, C., Hamilton, B., Brophy, L., Roper, C., McSherry, B., & Young, J. T. (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), 535-544.
[7] Mohr, W.K., Petti, T.A., and Mohr, B.D. (2003), Adverse Effects Associated with Physical Restraint, 48 Canadian Journal of Psychiatry 5 (2003) at 330-337.
[8] Barnett, R., Stirling, C., Pandyan, A.D. (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. Med Sci Law. 2012:52(3):137-42.

The following principles will help services apply these guidelines in line with Te Tiriti.[9]

Tino rangatiratanga: The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.

Equity: The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.

Active protection: The principle of active protection, which 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, which 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 appropriate way that recognises and supports the expression of hauora Māori models of care.

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

1.2.2. Respect for cultural identity

The Mental Health Act (section 5) requires the powers of the Mental Health Act 'to be exercised with proper respect for cultural identity and personal beliefs', including:

- with proper recognition of the importance and significance to the person of the person's ties with [their] family, whānau, hapū, iwi, and family group, and
- with proper recognition of the contribution those ties make to the person's wellbeing, and
- with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.

> 'Every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5': powers to be exercised with proper respect for cultural identity and personal beliefs'
>
> *Mental Health Act, sections 5 and 65*

The patient right articulated in section 65 of the Mental Health Act requires that 'Every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5.' The inclusion of whānau and kaimahi Māori is particularly important for upholding this right and providing for tāngata whai ora Māori.

The *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (the Guidelines to the Mental Health Act)[10] describe how Te Tiriti o Waitangi and its principles relate

[9] https://www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi
[10] Ministry of Health. 2020. Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health.

to the application of the Mental Health Act and outlines how clinicians and services can align their practices with these principles.

1.2.3. Achieving equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable, but unfair and unjust. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.[11] Additionally, there are differences in treatment and care that are also inequitable for tāngata whai ora Māori.

Māori and Pacific people are significantly more likely to experience seclusion and restraint than other ethnicities, even when accounting for demographic differences.[12] These inequities are unacceptable and must be addressed by mental health services with urgency.

The Guidelines to the Mental Health Act state 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, spiritual, social, and ethnic groups, including the needs, values, and beliefs of Māori and
- in addition to implementing operational policies and strategies in culturally competent best-practice approaches, services must receive training and implement operational policies and strategies in culturally competent best-practice approaches that positively and authentically address the high rates of restraint used for Māori and Pacific people.

1.2.4. International human rights agreements

Aotearoa New Zealand has obligations to 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
- United Nations Convention on the Rights of Persons with Disabilities (CRPD)
- United Nations Convention on the Rights of the Child
- United Nations Declaration on the Rights of Indigenous Peoples
- 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*[13], a guidance document issued by the Ministry of Health and available at www.health.govt.nz.

1.2.5. 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 obligations in domestic law. The Health and Disability Commissioner

[11] Ministry of Health definition of equity, 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
[12] https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-annual-report-2018-and-2019
[13] Ministry of Health. 2020. Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health.

(Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Code of Rights) is the mechanism for protecting people's rights in relation to health and disability care.

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.

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*.[14]

1.2.6. He Ara Oranga

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga) 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.'[15] The Government has accepted the recommendation to repeal and replace the Mental Health Act, and this work is underway.

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."[16]

1.2.7. 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 to ensure agreed minimum staffing ratios in each healthcare workplace to provide safe and effective care to people using the service and the people providing the service. This includes agreements to increase staffing levels when the level of acuity in the workplace increases to a point that it is unsafe for staff and people using the service.

1.3. Ngā Paerewa Health and Disability Services Standard

The Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (Ngā Paerewa) sets out the requirements for providers of health and disability services.[17]

[14] Ministry of Health. 2020. Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health.
[15] He Ara Oranga, p.14
[16] He Ara Oranga, p.189
[17] Ngā Paerewa came into effect on 28 February 2022, replacing the Health and Disability Services Standards (NZS 8134:2008).

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

Outcome 6 'Here Taratahi' relates to restraint and seclusion and says 'Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.'

There are four sets of criteria under outcome 6: restraint processes, safe restraint, quality review, and seclusion. These criteria include a greater emphasis on governance, leadership and monitoring, and debriefing following a restraint or seclusion event, compared with the previous set of health and disability standards.

The intention of these guidelines is to help services meet the requirements of Ngā Paerewa set out in Outcome 6. It is important that Ngā Paerewa is interpreted in a matter that is consistent with Te Tiriti o Waitangi 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 6.1 are:

The People: People with lived experience trust the service provider is committed to improving policies, systems, and processes to ensure that they are free from restrictions. People with lived experience want to have options that enable freedom and ensure their care and support adapts when needs change, and they want to trust that the least restrictive options are used first.

Te Tiriti: 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.

Service Providers: Service providers demonstrate the rationale for the use of restraint in the context of aiming for elimination. Service providers consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.

1.4. Definitions of restraint and seclusion

1.4.1. 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' (Nga Paerewa, 0.3).

For the purposes of these guidelines, the following definitions of different types of restraint are used:[18]

- **Personal**, where a service provider uses their own body to intentionally limit the movement of a consumer[19]

[18] These definitions have been taken from the (now superseded) Health and Disability Services Standards (NZS 8134:2008)
[19] In other jurisdictions personal restraint is called physical restraint.

- **Physical**, where a service provider uses equipment, devices or furniture that limits the consumer's normal freedom of movement[20]

1.4.2. 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 states that 'Every patient is entitled to the company of others, except [where] it is necessary for the care or treatment of the patient, or the protection of other patients.'

1.4.3. Sedative medication

The use of medications solely for the purpose of controlling a person's behaviour is often referred to as 'chemical restraint'. The prescribing of sedative medications is a matter of clinical decision-making and is outside the scope of these guidelines. However, it is recognised that the use of sedation to control behaviour is a very restrictive intervention, with potentially serious consequences for the person being sedated.

In 2019, the Royal Australian and New Zealand College of Psychiatrists endorsed a *Guideline for Safe Care for Patients Sedated in Health Care Facilities for Acute Behavioural Disturbance*.[21] 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 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.'[22]

Section 66 of the Mental Health Act sets out a person's right for 'medical treatment and other health care appropriate to his or her 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 have the option of making a complaint to a district inspector for mental health or the Health and Disability Commissioner.

[20] In other jurisdictions physical restraint is called mechanical restraint.
[21] https://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
[22] Above n 20, page 3.

2. Principles for the use of seclusion and restraint

These principles have been adapted from the Guidelines to the Mental Health Act.

> 'Every patient is entitled to the company of others' (*Section 71(1), Mental Health Act)*

Seclusion and restraint must be used with the least amount of force necessary once all other options have been explored to maintain the safety of the person experiencing distress, staff, or others in the inpatient environment.

The duration of seclusion or restraint must be for the shortest possible time it takes to safely manage the situation and must be guided by legal, ethical, and trauma-informed care principles.

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. 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.

If a restraint occurs, staff must **uphold the dignity, privacy, 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.

Seclusion and restraint shall not be used by health services for punitive reasons.

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 experience of mental distress.

> 'People with lived experience trust the service provider is committed to improving policies, systems and processes to ensure I am free from restrictions.'
> *Ngā Paerewa Health and Disability Services Standard 6.1.*

3.1. Six Core Strategies

The Six Core Strategies© are evidence-informed approaches effective in reducing seclusion and restraint events for both adults and young people.[23][24] Te Pou has adapted the Six Core Strategies to support services to implement them within an Aotearoa New Zealand context.

[23] This whole-of-system approach was originally developed in the US by the National Association of State Mental Health Program Directors Medical Directors Council (NASMHPD).
[24] Azeem, 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."

The Six Core Strategies© service review tool (2020)[25] 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 practice through identifying key priorities and supporting ongoing quality improvement and systems change.

The Six Core Strategies resources are available on the Te Pou website.[26] The tool includes a commitment to the principles of Te Tiriti o Waitangi and cultural, human-rights and trauma informed approaches. The six core strategy areas are:

- leadership towards organisational change
- full inclusion of people with experience of mental distress
- 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 focuses on eliminating seclusion in Aotearoa New Zealand. The project is part of the Health Quality and Safety Commission's (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, which began in early 2019.

The Zero Seclusion project aims to improve the experience of care for consumers by further reducing seclusion rates in all acute mental health units, with a goal of elimination.

The HQSC supports health providers to find other ways to help people in distress, as alternatives to seclusion.

Quality improvement methodology is used to develop and test what works best for the people and staff of a particular service. The project has shown effective ways to support people in distress and help avoid the use of seclusion, including:

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

[25] Te Pou. (2020). Six Core Strategies© service review tool: New Zealand adaption (2nd edition). Auckland: Te Pou.
[26] www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/the-six-core-strategies-service-review-tool

The Zero Seclusion project has produced a range of evidence-based resources to support services to reduce and eliminate seclusion, available on the HQSC's website.[27] These include:

- case studies showing how mental health inpatient services have successfully further reduced their use of seclusion with some achieving zero seclusion for periods of time
- a change package which comprises a cultural kete and clinical package based on practice evidence of what has been shown to work well[28]
- pono consumer and whānau video narratives.[29]

3.3. Safe Practice Effective Communication

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 training in restraint minimisation, communication, de-escalation, collaborative ways of working, and the teaching of personal restraint and breakaway techniques.

The Guidelines to the Mental Health Act endorse current SPEC training principles[30], to optimise the physical safety of the person being restrained. SPEC 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. It also degrades the person's mana and dignity.

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 whai ora and their whānau/aiga.

More information about SPEC training is available on Te Pou's website[31].

4. Person-centred approaches to preventing seclusion and restraint

This section presents methods of working with people in mental distress that have been shown to be effective at minimising the use of seclusion and restraint.

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."[32]

[27] https://www.hqsc.govt.nz/our-work/mental-health-and-addiction-quality-improvement/projects/zero-seclusion-safety-and-dignity-for-all/
[28] https://www.hqsc.govt.nz/our-work/mental-health-and-addiction-quality-improvement/projects/zero-seclusion-safety-and-dignity-for-all/
[29] https://www.hqsc.govt.nz/news/consumers-experience-of-seclusion/
[30] See section 15.7.3 of the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992.
[31] https://www.tepou.co.nz
[32] Ngā Paerewa, page 9.

4.1. 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 full legal capacity, no matter what their cognitive status (Snelling 2019).[33]

Supported decision-making is a central concept in the CRPD, which requires state parties to ensure people have the support needed to, among other things, make decisions about their medical treatment (Article 12).

The concept and practice of supported decision-making and how it relates to the Mental Health Act is detailed in our guidance titled *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992.*[34]

The Ministry of Social Development[35] website also has useful information and resources about supported decision-making.

4.2. Advance directives

Advance directives are a tool for supported decision-making. An advance directive is a written or oral directive or instruction in which a person tells health professionals about specific kinds of treatment that they would or would not want no matter how sick they are.

Right 7(5) of the Code of Rights states, 'Every consumer may use an advance directive in accordance with the common law'. The person may also specify who they wish to have, or not have, involved in their care.

An advance directive is also sometimes called a Mental Health Advance Preference Statement or MAP. Southern Health has developed and trialled this new advance directive tool in collaboration with the University of Auckland. [36][37]

More information about advance directives and the Mental Health Act is available in our guidance titled *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992.*[38]

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

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

[35] See msd.govt.nz/about-msd-and-our-work/work-programmes/accessibility/supported-decision-making.html

[36] See www.southernhealth.nz/getting-help-you-need/mental-health-and-addictions/mental-health-advance-preferences-statement

[37] Thom K, Lenagh-Glue J, O'Brien AJ, Potiki J, Casey H, Dawson J, Glue P. Service user, whānau and peer support workers' perceptions of advance directives for mental health. Int J Ment Health Nurs. 2019 Dec;28(6):1296-1305. doi: 10.1111/inm.12637. Epub 2019 Jul 30. PMID: 31361087

[38] Ibid at 39

4.3. Trauma informed approaches

There is a growing awareness of the relationship between trauma and wellbeing. While definitions of trauma vary, the 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.' [39] For Māori, these experiences may include colonisation, racism and discrimination, and health or social disparities.[40]

It is recognised that seclusion and restraint are traumatising experiences for people, their whānau and staff.

Trauma informed approaches[41] are grounded in an understanding of and responsiveness to the impact of trauma on people's lives. Cultural awareness is essential to ensure that such approaches are effective for all people.

> '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'. *Te Pou (2021). Weaving together knowledge for wellbeing - Trauma informed approaches.*

Trauma potentially impacts 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 people out of 10 in the general population).[42] Additionally, young people who are admitted to mental health inpatient settings are likely to have experienced trauma in their life, with more than a third of one large sample having experienced sexual or physical abuse.[43]

Trauma-informed approaches are included in the seven 'Real Skills' for health professionals working with people and whānau with mental health and addiction needs.[44] In addition, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommends that:

> 'Individual psychiatrists enhance their own knowledge and skills in TIP [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.'[45]

[39] Adapted from the Substance Abuse and Mental Health Services Administration (2021), in *Weaving together knowledge for wellbeing Trauma informed approaches.* Te Rau Ora, Le Va, Werry Workforce Whāraurau, MatuaRaki, Te Pou.
[40] Pihama, L., Smith, L. T., Evans-Campbell, T., Kohu-Morgan, H., Cameron, N., Mataki, T., ... & Southey, K. (2017). Investigating Māori approaches to trauma informed care.
[41] The terms 'trauma informed care' and 'trauma informed practice' are also used.
[42] *Weaving together knowledge for wellbeing Trauma informed approaches.* Te Rau Ora, Le Va, Werry Workforce Whāraurau, MatuaRaki, Te Pou
[43] Bryson, S. A., et al. (2017).
[44] https://www.tepou.co.nz/initiatives/lets-get-real/seven-real-skills
[45] RANZCP position statement on trauma-informed practice, November 2020, at www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/trauma-informed-practice

Among the benefits of a trauma-informed approach, research has shown that it can reduce the use of seclusion and shorten adult inpatient stays.[46] Additionally, a trauma informed treatment approach with children and young people has been shown to reduce the number of physical restraints and seclusion incidents. [47]

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

- *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 Aotearoa[48]:
- Te Pou – a collection of resources and e-learning
- Le Va – trauma-informed approach when working with Pasifika people (September 2019)[49]
- Werry Workforce Whāraurau – training and resources focused on the needs of rangatahi/young people[50]
- A video by Dr Kiri Prentice resource about how tikanga-informed care is part of trauma-informed care for tāngata whai ora Māori[51]
- Kaupapa Māori approaches to trauma informed care, a presentation by Dr Linda Tuhiwai Smith [52]
- RANZCP position statement on trauma-informed practice.[53] https://www.health.govt.nz/system/files/documents/publications/human-rights-mental-health-compulsory-assessment-treatment-act-1992-28august2020v2.pdf

4.4. Individualised care planning

Situations that a person may find distressing, indicating that they need care, and helpful de-escalation techniques differ from person to person. It is therefore important that services develop individualised care plans for supporting people in distress.

Planning may include the use of advance directives, culturally specific plans, wellness plans, crisis plans, relapse prevention plans, or sensory modulation plans. It is important that individualised plans are co-developed with people and their whānau, where appropriate.

These plans may indicate what situations are likely to cause distress, which behaviours indicate the person needs care and which type of care 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 any substance use issues. This will help to reduce the use of

[46] Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development?. *Mental Health Review Journal.*
[47] Boel-Studt, S. M. (2017). A quasi-experimental study of trauma-informed psychiatric residential treatment for children and adolescents.
[48] www.tepou.co.nz/resources/weaving-together-knowledge-for-wellbeing-trauma-informed-approaches
[49] www.leva.co.nz/resources/a-trauma-informed-approach-when-working-with-pasifika-people/
[50] www.wharaurau.org.nz
[51] www.youtube.com/watch?v=WKLKI9Ot_fE
[52] https://www.youtube.com/watch?v=GN3tu5FOOa0
[53] www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/trauma-informed-practice

restrictive practices as stressful situations can be avoided or managed with greater support, de-escalation techniques, and timely, and effective alternatives to restraint and seclusion.

The Ministry of Health recommends that these plans are developed collaboratively with the person and, where appropriate, their whānau/family and support people. It is important that plans include consideration of any communication needs the person may have, such as whether the person needs an interpreter to communicate, including for New Zealand Sign Language. People with an intellectual disability or neurodevelopment disorder will likely have specific communication needs that need to be considered.

4.5. Leadership and governance

Governance and leadership, at the executive level, are essential for services to achieve a seclusion and restraint-free environment. Ngā Paerewa includes criteria for governance bodies and executive leadership to demonstrate commitment towards eliminating seclusion and restraint in addition to ensuring that the voices of people, Māori and whānau are evident in restraint oversight groups.

> 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. *RANZCP. Position Statement 61. August 2021*

Additionally, the Guidelines to the Mental Health Act[54] state that services are required to

- 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.

4.6. Working in partnership with Māori

In line with Te Tiriti o Waitangi obligations and sections 5 and 65 of the Mental Health Act, services are expected to work in partnership with Māori tāngata whai ora and their whānau.

> 'Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices.' *Ngā Parewa 6.1*

Whānau, kaimahi Māori, cultural advisors, kaumātua and tohunga (where available) should be actively engaged in promoting least restrictive best practice, including active support of and communication with Māori tāngata whai ora and whānau, when restraint occurs. Therefore, in the first instance, staff should use these supports wherever practicable before considering whether to use restraint and seclusion.

4.7. Cultural safety

Ngā Paerewa defines cultural safety as '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

[54] See section 15.7.3 of the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992.

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.'[55]

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

Cultural safety recognises that people have different needs in relation to their cultural identity. It is an important part of delivering person-centred care and achieving equity for Māori and other groups of people who experience health disparities.

The need for a cultural assessment is emphasises in Ngā Paerewa (criteria 3.2.2 and 6.2.1) and the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (see section 4.1.1 Culturally safe care).

Understanding one's own biases and how these biases may impact on people in inpatient services is part of culturally safe practice. The HQSC has developed e-learning resources on understanding bias in health care[56]. It also has an e-learning module on Implicit Bias and Best Practice developed specifically for mental health and addiction staff and is available on every service's learning platform.

The New Zealand Medical Council is committed to improving cultural safety and some resources are available on the Council's website.[57]

Cultural safety may be improved with access to cultural supervision. The process of cultural supervision allows staff members an opportunity to reflect on their practice of engaging with Māori in challenging situations.

4.8. Welcoming new admissions

Engaging with people and their whānau on admission in a way that maintains their mana and dignity can help relieve anxiety and prevent feelings of distress. This can be achieved by being thoughtful about how the person is greeted (eg, a large team of staff is intimidating). Simple actions like offering someone a drink and/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. It is essential to a safe and supportive admission that staff clearly introduce themselves to tāngata whai ora and are clear about who will be involved in their care and treatment.

Māori may benefit from being welcomed with pōwhiri processes, images of journeys, and recitation of the pūrākau (Māori creation narratives). This process can make sure people feel welcome, safe, and supported. Creating a culturally healing environment may include having a kaumātua come bless the space and cleanse the energies, access to natural greenspaces, and

[55] Ngā Paerewa Health and Disability Services Standards (NZS 8134:2021), 0.3
[56] www.hqsc.govt.nz/our-programmes/patient-safety-day/publications-and-resources/publication/3866
[57] www.mcnz.org.nz

shared spaces for kai Māori, waiata and other activities.[58] It is also important to be mindful of the physical environment and subtle changes to ensure this looks more welcoming.

Including whānau and/or support people may help people to feel safer and more comfortable. Where possible, being able to provide an extra bed for a person's partner or whānau member to stay is also useful. This is especially important for young people and rangatahi Māori.

It is also important that staff are aware of people's experience pre-admission, such as the way in which they were brought to the inpatient unit or whether they have used substances, and how this may contribute to their presentation on admission. This will help facilitate a safe and supportive welcome on admission. Tāngata whai ora Māori may wish to have the support of a tohunga or kaumātua during the assessment process.

4.9. Whakaāio ā-rongo or sensory modulation

Sensory modulation is an effective practical approach to support people when feeling distressed. The use of this approach has been used as one of multiple strategies to successfully reduce seclusion and restraint in mental health units.[5960]

Staff should be trained in sensory modulation to support the person in managing distress and develop self-regulation skills. Staff should work with the person to identify and create a sensory modulation toolkit that would be most helpful with the person in management of distress.

A designated sensory space in mental health unit should be available with sensory resources that may help comfort the person. These resources may include music, aromatherapy, weighted modalities and comfortable seating. Sensory resources should be considered on an individual basis to ensure optimum sensory experience of the person.

More information on the use of sensory modulation can be found on the Te Pou[61] and HQSC[62] websites.

4.10. Weighted blankets

Weighted blankets are often used as a form of sensory therapy. Weighted blankets are often used 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.[6364]

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[58] Te Pou, Least Restrictive Practice Evidence Update, May 2021

59 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. https://doi.org/10.1080/18374905.2014.11081887

[60] Sutton, D., Wilson, M., Van Kessel, K., & Vanderpyl, J. (2013). Optimizing arousal to manage aggression: A pilot study of sensory modulation. International journal of mental health nursing, 22(6), 500-511. https://doi.org/10.1111/inm.12010

[61] www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/sensory-modulation

[62] https://www.hqsc.govt.nz/news/mental-health-and-addiction-quality-improvement-programme-update/

[63] Mullen, B., Champagne, T., Krishnamurty, S., Dickson, D., & Gao, R. X. (2008). Exploring the safety and therapeutic effects of deep pressure stimulation using a weighted blanket. Occupational Therapy in Mental Health, 24, 65–89.

[64] Champagne, T., Mullen, B., Dickson, D., & Krishnamurty, S. (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), 211-233.

It is important that the services take a trauma informed approach to the use of weighted blankets, as being covered may be re-traumatising for some people. It is essential that services ensure the person can remove the blanket on their own and monitor the person for any discomfort during their use.

Guidelines for the safe use of weighted blankets can be found in Te Pou's least restrictive practice evidence update, October 2021.[65]

4.11. 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 of conflict or injustice come together, in a safe and respectful environment.'[66]

Restorative approaches aim for a collective understanding of an adverse event which can help clarify responsibilities, inform action, and heal individuals and relationships.[67]

The principles of restorative practice align well with tikanga Māori concepts of justice and collective responsibility.[68] Services are strongly encouraged to consider the use of restorative practices with Māori tāngata whai ora.[69]

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

Within a healthcare setting, restorative approaches have been shown to create a more open and trusting culture, and have resulted in increased engagement, psychological safety, and reduced stress for staff.[70]

The HQSC has promoted restorative practices as a way of responding to adverse events in healthcare settings. Information and resources are available on the Commission's website.[71] A restorative approach may help services conduct a meaningful, person- and whānau-centred debrief after episodes of emergency restraint and seclusion, as required by Ngā Paerewa (criteria 6.2.5 and 6.4.5).

[65] www.tepou.co.nz/resources/least-restrictive-practice-evidence-update-october-2021

[66] Marshall, Christopher D. "Restorative justice." Religion Matters. Springer, Singapore, 2020. 101-117.

[67] Jo Wailing, Using a restorative approach to respond to adverse events, blog entry 29 Aug 2019. https://www.hqsc.govt.nz/news/blog-using-a-restorative-approach-to-respond-to-adverse-events/

[68] https://www.resolution.institute/documents/item/1774

[69] Wharewera-Mika, J. P., Cooper, E. P., Wiki, N. R., Field, T. R., Haitana, J., Toko, M., Edwards, E., & McKenna, B. R. (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), 258–265.

[70] Kaur, M., De Boer, R. J., Oates, A., Rafferty, J., & Dekker, S. (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.

[71] www.hqsc.govt.nz

5. Considerations for tamariki and rangatahi

Whilst the guidance and methods outlined above is relevant and beneficial to use with children and young people, this section presents specific considerations. Methods that have been shown to be effective at minimising the use of seclusion and restraint with children and young people are also presented.

Children and young people have a range of unique needs, vulnerabilities, and characteristics that need to be considered when planning and providing care, including in environments where restrictive practices may be used.

Staff should remember their obligations under the United Nations Convention on the Rights of the Child[72] 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."

Additionally, the younger a person is, the greater duty of care needed. 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. For people aged 16 and over, the Mental Health Act (section 87) states that the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of this Act. This means that consent to treatment for young people aged 16 and over must comply with the requirements of section 59 of the Mental Health Act.[73] Children and young people should be involved in the decisions about their care and treatment where possible.

5.2. Understanding children and young people

It's important that staff acknowledge that children and young people's experience and views of the world are different to adults. Staff should have a good understanding of youth culture, what's important to children and young people, how they like to express themselves, and how they experience distress and mental health issues.

Service providers should be aware of the developmental needs of staff working in environments where children and young people may be subject to restrictive practices. Staff should be

[72] https://www.justice.govt.nz/justice-sector-policy/constitutional-issues-and-human-rights/human-rights/international-human-rights/crc/

[73] See *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* for guidance on consent and second opinions for treatment under the Mental Health Act.

supported to develop a good understanding of child and youth development and communication styles.

It's important that staff 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
- experience a heightened power imbalance with adults.[74]

As set out in Part 8 of the current Mental Health Act, 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, it is important to consider this on an individual basis.

Where possible, the 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 the 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'. For some young people, there was an automatic sense of connection with younger clinicians who they felt shared their worldview".[75]

5.3. The role of family/ whānau

Family and whānau play a central role in the lives of children and young people. They can provide useful information about situations that may cause a child or young person distress and help prevent the use of restrictive practices. They can also be an effective support for children and young people when they are distressed, which may help to further prevent the use of restrictive practices.

It is important that services consider how the knowledge of children or young people held by family and whānau can be incorporated into their care and treatment plans. Services should also ensure that children and young people are able to enjoy time and contact with family and whānau whilst they are admitted to an inpatient unit. This can help reduce distress for young people.

Many children and young people are admitted to inpatient settings away from their hometown in Aotearoa. It is important that services proactively support visiting and contact with family and whānau, including by video technology.

[74] Christie, D., & Viner, R. (2005). Adolescent development. *BMJ (Clinical research ed.)*, *330*(7486), 301–304. https://doi.org/10.1136/bmj.330.7486.301.
[75] Gibson, Kerry. (2022). What young people want from mental health services: a youth informed approach for the digital age, Routledge.

5.4. Approaches to prevent the use of seclusion and restraint

The use of restraint and seclusion on children and young people in an inpatient setting has been found to negatively impact the overall value and safety of care.[76] Additionally, children's experience of seclusion and restraint is negative, with feelings of fear, abandonment and punishment reported.[77] Therefore, it is essential that every effort to utilise alternative methods is explored, before the use of seclusion or restraint are considered.

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

- Collaborative Problem Solving (also called Collaborative & Proactive Solutions)[78]
- Attachment, Regulation and Competency model[79]
- Trauma informed approaches[80]
- Mindfulness-Based Stress Reduction Training (MBSR).[81]

Whilst these models have been effective at reducing restrictive practices, 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. This includes an understanding of how limits are set and expectations expressed by adults may influence or precipitate those behaviours, leading to an approach that emphasises crisis prevention over crisis management.[82]

6. Safely using restraint under the Mental Health Act

The outcome sought by Ngā Paerewa Section 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.'

[76] Magnowski, S. R., et al. (2020). "Algorithmic Prediction of Restraint and Seclusion in an Inpatient Child and Adolescent Psychiatric Population.

[77] Montreuil, M., et al. (2018). "Children's moral experiences of crisis management in a child mental health setting." International journal of mental health nursing **27**(5): 1440-1448.

[78] Black, V., 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): 578-584.

[79] Hodgdon, H. B., Kinniburgh, K., Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal of Family Violence*, *28*(7), 679-692.

[80] Boel-Studt, S. M. (2017). "A quasi-experimental study of trauma-informed psychiatric residential treatment for children and adolescents." Research on Social Work Practice **27**(3): 273-282.

[81] Perers, C., et al. (2021). "Methods and Strategies for Reducing Seclusion and Restraint in Child and Adolescent Psychiatric Inpatient Care." The Psychiatric quarterly.

[82] Bryson., 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.

The outcome statements of Ngā Paerewa Section 6.2 *Herenga haumaru Safe restraint* are:

The People: People with lived experience have options that enable their freedom and ensure their care and support adapts when their needs change, and I trust that the least restrictive options are used first.

Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort.

Service providers consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort.

6.1. 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 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 Mental Health Act Guidelines (especially section 15.7), which provides guidance for the use of force under the Mental Health Act.

Restraint in health settings is also permitted in certain circumstances under the Crimes Act 1961 to prevent injury to self or others. This includes a duty, under section 151 of the Crimes Act, of people providing care to a vulnerable person "to take reasonable steps to protect that person from injury." Appendix A details the justifications for the use of force in certain sections of the Crimes Act.

Restraint should only be used once less restrictive measures have proved unsuccessful, and only to the extent that is 'reasonably necessary in the circumstances.' It is a serious intervention requiring robust clinical justification and oversight. If restraint is used, staff have a duty of care to mitigate the potential psychological and physical harms that can occur.

6.2. Restricting a person's movement

Ngā Paerewa defines restraint as "The use of any intervention by a service provider that limits a person's normal freedom of movement." Actions that limit a person's normal freedom of movement include 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 and right to liberty.

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

Where a decision is made to limit a person's normal freedom of movement within the environment of inpatient mental health unit, this must be recorded as an episode of restraint in

the service's reportable event system. Director of Area Mental Health Services must report restraint use to the Director of Mental Health in their quarterly reports.

If internal doors are locked, it is essential that the unit staff restore access to all the areas of the unit that people would ordinarily have access to as soon as practicable and safe.

People who need mobility aids such as a wheelchair should not be prevented under any circumstances from accessing those aids as a means of limiting their movement.

6.2.1. 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 have been assessed as needing that level of care and support.

A person who is receiving treatment voluntarily should only be placed in a locked unit with their informed consent, which 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. It is important that services make voluntary tāngata whai ora aware that they can exit the unit as soon as reasonably practical if they wish. Clear signage informing voluntary tāngata whai ora how to exit a locked unit should always be displayed.

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 people in the unit.

6.3. Decisions to approve restraint

Consistent with Ngā Paerewa criteria 6.2.1, decisions to approve restraint for tāngata whai ora must 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 professional
- when the environment is appropriate and safe.

For the purposes of these guidelines, and for the sake of clarity, the term 'last resort' means that seclusion and restraint are not used unless other non-restrictive approaches have been tried but have failed to alleviate the person's distress to the extent that their safety and the safety or others is assured. The intervention of 'last resort' that is selected must be a proportionate response to the concerns about the safety of the person and others.

6.3.1. Physical and psychological health considerations

It is important to monitor a person's physical health during a period of restraint. No use of restraint is completely safe. Personal restraint has physical health risks for the person being restrained that can result in injury or death. In general, people with experience of severe mental

distress factors have poorer physical health, which puts them at higher risk of physical harm occurring during a restraint incident. Research has also shown that young people are at a higher risk of injury or harm resulting from restraint.[83]

A person's risk of injury or death resulting from a restraint incident increases with the presence of several factors, including but not limited to:

- pre-existing health conditions
- positional asphyxia
- excited delirium/acute behavioural disturbance
- substance use.[84]

As noted in section 1.1, there are also psychological consequences of using seclusion and restraint that need to be mitigated as much as possible when restraint is used.

6.3.2. Other safety considerations

It is important that staff consider a person's trauma history, possible recent substance use, and cultural needs before a decision to use restraint. It is also important that relevant cultural advice be sought to maintain cultural safety. A person's sensory differences or sensitivities (for example, people with autism may be distressed by touch) and any communication needs are also an important part of the decision about whether restraint can be safely used.

6.4. Quality review of restraint

The outcome statements of Ngā Paerewa 6.3 *Arotake kounga o te herenga Quality review of restraint* are:

The People: People with lived experience feel safe to share their experiences of restraint so they can influence least restrictive practice.

We maintain or are working

Te Tiriti: 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: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities.

People with lived

6.4.1. Monitoring and recording restraint

The frequency and extent of monitoring of people during restraint must be determined by a registered health professional (Ngā Paerewa 6.2.2).

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

[83] Mohr, W.K., Petti, T.A., and Mohr, B.D. (2003), Adverse Effects Associated with Physical Restraint, 48 Canadian Journal of Psychiatry 5 (2003) at 330-337.
[84] 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), 719-726.

Each episode of restraint shall be documented on a restraint register (as required by section 129(1)(b) of the Mental Health Act), and in people's clinical records. Episodes of restraint must be recorded in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint. Consistent with criteria 6.2.4 of Ngā Paerewa, the restraint register must include:

- the type of restraint used
- details of the reasons for initiating the restraint
- the decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered prior to the use of restraint
- 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
- any impact, injury, and trauma on the person as a result of the use of restraint
- observations and monitoring of the person during the restraint
- comments resulting from the evaluation of the restraint
- a record of the person-centred debrief, including support offered after the restraint, particularly where trauma has occurred (eg, psychological or cultural trauma).

Consistent with criteria 6.3.1 of Ngā Paerewa, service providers shall conduct comprehensive reviews at least **six-monthly** of all restraint practices used by the service, including:

- that a human rights-based approach underpins the review process
- the extent of restraint, the types of restraint being used, and any trends
- 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 where 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 and whānau perspectives 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 (changes to care or support plans and documenting and analysing learnings from each event)
- service provider initiatives and approaches supporting a restraint-free environment
- the outcome of the review is reported to the governance body.

6.4.2. Reporting to the Ministry of Health

The Director of Mental Health requires Directors of Area Mental Health Services 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 person and the type of restraint used.

6.4.3. Debrief

Ngā Paerewa criteria 6.2.5 states: A person-centred debrief must follow every episode of emergency restraint. Participation in the debrief should be determined by the person, at a time when they feel ready.

This is supported by the Mental Health Act Guidelines, section 15.7.3, 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.[85]

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

It is important that services seek the person's preferences for who they would like to do the debrief with. Tāngata whai ora Māori should be offered a cultural advisor or kaimahi Māori to conduct their debrief. People may also wish to include lived experience advisors, independent advocates and family/whānau in the debrief process.

A restorative practice approach may be an effective and appropriate method of debriefing after a restraint event (see 4.10 Restorative practice). For Māori tāngata whai ora, it may be appropriate for services to incorporate the principles of hohourongo[86] into the debrief process.

It is important for staff to remind tāngata whai ora 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, they should be assisted to do so and provided with the relevant information in an appropriate way. Complaints can be made through the health service directly or via district inspectors of mental health. Services should also remind people of the free Health and Disability Commissioner Advocacy service, which can support people to lay a complaint.

6.4.4. Evaluation

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

- time intervals between the debrief process and evaluation process
- 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
- the impact the restraint had on others
- 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

[85] Mental Health Act guidelines, p.130.

[86] See for example https://www.psychology.org.nz/journal-archive/NZJP-Vol372-2008-3-Rata.pdf

- 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
- 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).[87]

7. Safely using seclusion under the Mental Health Act

The outcome sought by Ngā Paerewa Section 6.4 *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'.

The outcome statements in Ngā Paerewa 6.4 *Taratahi Seclusion* are:

The People: People with lived experience 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.

Te Tiriti: Service providers take a person- and whānau-centred approach, to ensure there is no seclusion. Service providers no longer consider seclusion a therapeutic intervention, and it only occur when our environment is not conducive to the elimination of seclusion.

Service Providers: Service providers no longer consider seclusion a therapeutic intervention, and it only occur when our environment is not conducive to the elimination of seclusion. Service providers take a person- and whānau-centred approach, to ensure there is no seclusion.

The Ministry of Health is committed to supporting the 'Zero seclusion: safety and dignity for all' project and criteria 6.4.1 of Ngā Paerewa, which states service providers shall work towards being seclusion free under the current Mental Health Act.

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

Under the current Mental Health Act seclusion may be lawfully used (as described below). However, consistent with these guidelines and Ngā Paerewa, seclusion should only be used under urgency or in emergency situations once all other less restrictive options have been tried.

While permitted under the current Mental Health Act, it is now understood that seclusion has no known therapeutic value. If seclusion cannot be avoided, staff have a duty of care to mitigate the

[87] Ngā Paerewa Health and Disability Services Standards (NZS 8134:2021), 6.2.7

potential psychological and physical harm that can occur. It is also essential that it is used safely and under the appropriate circumstances.

7.1. Seclusion under the Mental Health Act

Section 71 of the Mental Health Act states that a person has a right to company, and it also specifies the circumstances under which someone may be secluded under the Act:

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:
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).'

If seclusion is used, staff have a duty of care to mitigate the potential psychological and physical harm that can occur.

7.2. Individualised care

It is important that decisions around the use of seclusion are made on an individual basis. Staff may be able to refer to a person's advance directive when considering the use of seclusion.

It is important for staff to consider a person's trauma history and cultural needs before a decision on the use of seclusion is made. This includes seeking relevant cultural advice. It is also important that a person's sensory differences or sensitivities (for example, people with autism may be distressed by touch) and any communication needs form part of a decision about whether seclusion can be safely used.

7.3. Physical and psychological health considerations

It is essential to the safety of tāngata whai ora that their physical health be considered when using seclusion. **Extreme caution** should be applied when using 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
- The presence of a physical illness or injury requiring specific physical treatment

- The presence or likelihood of self-injurious behaviour
- The likelihood of escalation of anxiety, aggression or distress or a previous adverse response
- Intoxication or substance use with recent ingestion
- With children or young people
- Where a person has a disability or underlying health issues.

7.4. Providing a safe environment

Seclusion rooms need to be able to maintain the person's dignity and comfort without posing a risk for the person or staff.[88] Whilst this may be challenging, it is important to create an environment that supports recovery and safety. Services should refer to the current Australasian Health Facility Guidelines for the seclusion room requirements.[89]

Ngā Paerewa criteria 6.4.4 and section 71 of the Mental Health Act require that seclusion shall only take place in a designated seclusion room. The Mental Health Act requires designated seclusion rooms to be approved by the DAMHS (section 71(2)(b)). At a minimum, a seclusion room **must** have:

- adequate light, heat, and ventilation
- an accessible and safe way of dispensing 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
- fittings recessed to avoid potential for harm
- furnishings (other than bedding) that are fixed to avoid the potential for harm.

It is also essential to safe care that seclusion rooms have:

- doors opening outwards flush with the walls and an environment that is pleasant and minimally stimulating
- a means of orientation and connection (eg, installing a visible clock and calendar or access to news)
- access to toileting, washing and showering facilities in or adjacent to the seclusion room
- access to two-way communication
- access to an equally safe external area to assist with reintegration
- access to temperature regulation if required
- an external window.

It is recommended that services consider improving the physical appearance of seclusion rooms, to create an environment that is supportive of recovery and wellbeing.[90] Seclusion rooms have been criticised for their 'barren' and 'drab' appearance.[91] The colour of seclusion rooms may help to create a calm environment for people in seclusion. Any changes to the colour or appearance of

[88] Time for a Paradigm Shift. A Follow Up Review of Seclusion and Restraint Practices in New Zealand, Sharon Shalev, 2020.
[89] AusHFG | (healthfacilityguidelines.com.au)
[90] 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.
[91] Thinking outside the Box? A Review of Seclusion and Restraint Practices in New Zealand, Sharon Shalev, 2017

seclusion rooms should be co-designed with people who have experienced seclusion, cultural advisors and peer support workers.

Additionally, subject to safety considerations, it is important to consider people's access to personal items and ensure they access to resources required to meet spiritual and cultural needs. This can further help to create a homelike and healing environment.

The ability of a person to exercise personal autonomy whilst in seclusion should also be considered. 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 around the light and temperature of the seclusion room or access to drinking water and toileting.

The Ministry of Health appreciates that not all recommendations in this section can be implemented for existing seclusion rooms. Simple and non-costly recommendations, such as painting seclusion rooms and providing a visible clock should be followed. All other recommendations should be followed as closely as possible and considered in the refurbishment of seclusion rooms. Consideration should be given to the de-commissioning/re-purposing of seclusion rooms as the practice is further reduced and eliminated.

7.5. Commencing and ending seclusion

7.5.1. Commencing seclusion

A period of seclusion will commence when the person is placed alone in a room or area, from which they cannot freely exit.

7.5.2. Each initial seclusion episode is for a maximum of two hours

Each new seclusion episode shall be for a maximum of two hours.[92] The decision to place a person in seclusion must be taken by two suitably qualified clinicians[93] and authorised by the responsible clinician (if they are not one of the two clinicians).[94]

The reason for the use of seclusion should be explained to the person when placing them in seclusion and at any extensions of the episode of seclusion. The reasons for seclusion should be documented.

7.5.3. Extending seclusion beyond two hours

The seclusion episode should be ended as soon possible. For seclusion to be extended beyond two hours, the responsible clinician or two suitably qualified clinicians must assess the person's wellbeing and provide a reason for the continued use of seclusion. The responsible clinician should be notified as soon as practicable (if they are not one of the two clinicians). The reason for the continued use of seclusion must be explained to the person in seclusion and documented.

[92] Note: people may leave seclusion before the two-hour period if it is no longer needed.
[93] A suitably qualified clinician is either a registered nurse or a medical practitioner.
[94] The Mental Health Act (section 71(2)) requires that, except in an emergency, 'seclusion shall be used only with the authority of the responsible clinician'. '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.'

If a reason for the continued use of seclusion is not recorded after two hours, the seclusion episode is deemed to have ended and the person must be free to leave seclusion.

7.5.4. Eight-hourly assessments and care

If it is agreed that seclusion is still needed after the initial two hours, the seclusion episode may be extended for up to an additional eight hours. Throughout this eight-hour period, staff must continue to assess whether seclusion is still needed every two hours as described in 7.6.4 Mental and physical wellbeing assessment.

Before the end of an eight-hour period, two suitably qualified clinicians must assess the person and decide whether to further extend seclusion for up to another eight hours. A record of the eight-hour assessments should be documented. The responsible clinician should be notified as soon as practicable.

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

7.5.5. Ending seclusion

Each seclusion event should be for the shortest time possible. If the reasons for seclusion have been addressed, and seclusion is no longer needed, a decision to end seclusion must be taken by two 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, it is strongly recommended that staff consider whether seclusion is still necessary. However, it is not necessary to wake the person in order to end the episode of seclusion.

Each 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 one hour.

7.5.6. Reintegration

A planned and gradual process of reintegration into the ward should occur, particularly after a prolonged 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 open and move to integration during times of least stress and disruption, with increasing amounts of time. An assessment of reintegration attempts should be considered when deciding whether to continue seclusion. If 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 two suitably qualified clinicians determine that the aims of seclusion have not been met, and a further period of seclusion is required, this must be recorded 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.

7.5.7. Extended periods of seclusion

If over the course of one admission, the cumulative hours a person spends in seclusion **exceed 24 hours in a four-week period**, the Director of Area Mental Health Services and a local district inspector of mental health should be informed.

It is expected that assessment in the form of a **case review** should occur so that alternatives to the continued use of seclusion can be considered. It is important that the person's direct multi-disciplinary team, external clinical leadership, cultural advisors, and independent advocates are present at the case review. If appropriate, the person's family/ whānau should also be included.

If efforts to end seclusion are not successful following a case review, it is strongly recommended that services request an independent external review so that alternatives to the continued use of seclusion can be considered.

Additional considerations will need to be made for people who experience extended periods of seclusion. If the goals of seclusion are not met, and the decision to continue seclusion is made, staff should consider the person's ability to exercise and access meaningful activity. Services must also consider the impact of an extended period of seclusion on a person's right to company (Section 71, Mental Health Act).

7.6. Specific observation, engagement, and assessment requirements

7.6.1. Continuous observation

Observation of people in seclusion must be continuous.

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 physical observation and interaction with the person. Ngā Paerewa criteria 6.2.4(g) states that documentation of an episode of restraint should include observations and monitoring of the person during the restraint.

Individual preferences in relation to the staff member who is doing the observation should be followed where practically possible. For example, people may have a preference regarding the culture or gender of their observer. Individual preferences should be sought and recorded in the person's advance directive (or other individualised plan) and be considered by staff in the context of their trauma history. Individual preferences should be followed where practically possible.

The New Zealand Directors of Mental Health Nursing issued the following position statement on enhanced engagement and observations:

- it is important that staff view observations as an opportunity for therapeutic engagement, rather than an administrative task
- 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
- the model of care will inform enhanced engagement and observations
- there must be a clear rationale for the 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. Examples may include but are not limited to aspects of physical health status, colour, and respiratory function. These observations could be enhanced by technologies (for pulse checking) and could reduce the potential for error, especially in night observations
- preventing patients from harming themselves
- preventing patients from harming others.[95]

7.6.2. Engagement

It is not enough to simply observe people in seclusion, staff are also expected to intentionally engage with people in seclusion. An exception to this may be where the person is sleeping, and observation is sufficient to confirm signs of life and establish that they are not in physical distress. If a person in seclusion is asleep, 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.
> *(Hawkes Bay, observation and engagement policy, 2013)*

Engagement plays an important role in creating a healing environment, reducing a person's risk to themselves and promoting recovery. Engagement must occur in a safe and supportive way.

The need for, and type of, engagement will differ for each person in seclusion. For example, staff should consider a person's trauma history and the reason for their current seclusion episode before engagement is made. Engagement can include eye contact, conversation, or activities.

7.6.3. Entering and exiting seclusion room

Safety precautions must be taken when entering the room. The number of staff required to enter the room should be appropriate to manage potential risk involved. This should be determined prior to entry or detailed in service protocols.

7.6.4. Mental and physical wellbeing assessment

A suitably qualified clinician[96] must enter the room at least **once every two hours** to **assess the physical wellbeing** of the person 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 7.3 Physical and psychological health considerations. If an attempt to enter the room is unsuccessful, the reason must be recorded on the service provider's observations form.

In addition to assessing the person's physical wellbeing, an assessment of the person's mood and behaviour should be made at this time. The assessment should include physical observations including but not limited to level of consciousness, breathing, person's colour and vital signs.

[95] New Zealand Directors of Mental Health Nursing, Enhanced Engagement and Observation: A paper to inform the development of engagement and observation policies and procedures in inpatient units. (May, 2015).
[96] A suitably qualified clinician is either a registered nurse or a medical practitioner.

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

7.6.5. Clinical assessment

During the period of each shift, an ongoing programme of care and assessment must be provided and recorded. This includes:

- observations and care as described above are undertaken
- clinical consultation with the responsible clinician occurs and is documented
- communicating all care requirements both verbally and via the person's plan to 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 care should be carried out in accordance with the preferences of the person in seclusion. Considerations may need to be given to culture or gender. These preferences can be outlined in the person's advance directive (or other individualised plan) or considered in the context of their trauma history.

It is mandatory that once per shift, a suitably qualified clinician shall perform a clinical assessment of the person in seclusion, including a mental state examination. A record of the assessment must be documented.

7.7. Quality review of seclusion

7.7.1. Debrief

Ngā Paerewa criteria 6.2.5 states: A person-centred debrief must follow every episode of emergency restraint. Participation in the debrief should be determined by the person, at a time when they feel ready.

This is supported by the Mental Health Act guidelines, section 15.7.3, 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.[97]

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

It is important that services seek the person's preferences for who they would like to do the debrief with. Tāngata whai ora Māori should be offered a cultural advisor or kaimahi Māori to

[97] Mental Health Act guidelines, p.130.

conduct their debrief. People may also wish to include lived experience advisors, independent advocates and family/whānau in the debrief process.

A restorative practice approach may be an effective and appropriate method of debriefing after a restraint event (see 4.10 Restorative practice). For Māori tāngata whai ora, it may be appropriate for services to incorporate the principles of hohourongo (restoring peace and balance)[98] into the debrief process.

It is important for staff to remind tāngata whai ora 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, they should be assisted to do so and provided with the relevant information in an appropriate way. Complaints can be made through the health service directly or via district inspectors of mental health. Services should also remind people of the free Health and Disability Commissioner Advocacy service, which can support people to lay a complaint.

7.7.2. Evaluation

Ngā Paerewa 6.4.6 requires that each seclusion event shall be evaluated as soon as reasonably possible after the event. The evaluation is undertaken by registered health professionals from at least two different disciplines, a cultural advisor, and a lived experience advisor. Together, they 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 wellbeing, maximise learning from the evaluation of the seclusion event and to ensure safety for all in an environment of zero seclusion.[99]

[98] See for example https://www.psychology.org.nz/journal-archive/NZJP-Vol372-2008-3-Rata.pdf
[99] Ngā Paerewa Health and Disability Services Standards (NZS 8134:2021), 6.4.6.

7.7.3. Monitoring, recording and reporting seclusion

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

Each episode of seclusion shall be documented on a seclusion register (as required by section 129(1)(b) of the Mental Health Act), and in people's clinical records. Episodes of seclusion must be recorded in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome. Consistent with criteria 6.2.4 of Ngā Paerewa, the seclusion register should include:

- details of the reasons for initiating seclusion
- the decision-making process, including details of de-escalation techniques and alternative interventions that were attempted or considered prior to the use of 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 seclusion episode
- any impact, injury, and trauma on the person as a result of the use of seclusion
- observations and monitoring of the person during seclusion
- comments resulting from the evaluation of the seclusion
- a record of the person-centred debrief, including support offered after the restraint, particularly where trauma has occurred (eg, psychological, or cultural trauma).

In addition to this, mental health services are required to report to the Ministry of Health on the use of seclusion via PRIMHD for monitoring purposes.

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). Seclusion must only occur in a room or other area approved by the DAMHS, as required by section 71 of the Mental Health Act. However, if an individual is placed in *any* defined space on their own from which they cannot freely exit, whether or not it is a designated seclusion room, this meets the definition of seclusion and must be recorded and reported as such.

As in other aspects of the Mental Health Act, it is expected that district inspectors will monitor that procedures are properly used. One copy of the seclusion record should be retained on the person's clinical notes and one retained in a central seclusion register (as per section 129 of the Mental Health Act).

Seclusion data shall be provided to the service provider clinical governance body on a monthly basis (Ngā Paerewa 6.4.2).

Ngā Paerewa 6.4.7 requires that service providers conduct comprehensive reviews at least six-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
- the number of people secluded, the number of episodes of seclusion, their duration, demographics, and any trends

- 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.

The outcome of the review shall be reported to the service provider clinical governance body.

Glossary

Term	Definition
Code of Rights	Code of Health and Disability Services Consumers' Rights
Director of Area Mental Health Services (DAMHS)	DAMHS are appointed by the Director-General of Health under section 92 of the Mental Health Act. They are responsible for the day-to-day operation of the Mental Health Act in their appointed area. Guidelines for the role and function of DAMHS are available on the Ministry of Health website.
Director of Mental Health	The Director of Mental Health is appointed under section 91 of the Mental Health Act. The Director is responsible for the general administration of the Act.
District inspector	District inspectors are lawyers 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. They are independent from the Ministry of Health and from health and disability services. For more information see 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
Child/taitamaiti	A person under the age of 14 years, as defined in section 2(2) of the Oranga Tamariki Act 1989.
He Ara Oranga	*He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*
Lived experience	Ngā Paerewa defines lived experience as "Expertise, skills, and knowledge gained through direct, first-hand receipt of care of support services." (Ngā Paerewa, page 7).
Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act)	The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) provides a legal framework for those who require compulsory psychiatric assessment and treatment for people experiencing a mental illness. The Mental Health 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 person suffering from mental disorder.
Patient or proposed patient	A person receiving compulsory assessment and treatment under the Mental Health Act.
Ngā Paerewa	Ngā Paerewa Health and Disability Services Standard NZS 8134:2021
PRIMHD	The Programme for the Integration of Mental Health Data (PRIMHD) is a Ministry of Health single national mental health and addiction

	information collection of service activity and outcomes data for health consumers.
Responsible clinician	The clinician in charge of the treatment of that person.
Safe Practice and Effective Communication (SPEC)	SPEC is a national training course that supports best and least restrictive practice in mental health inpatient units.
Suitably qualified clinician	A registered nurse or a medical practitioner.
Tangata/tāngata whai ora Māori	A person/people receiving compulsory assessment and treatment under the Mental Health Act
United Nations Convention Against Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) and the Optional Protocol (OPCAT)	New Zealand ratified the UNCAT on 10 December 1989. OPCAT was ratified on 14 March 2007. For more information about UNCAT and OPCAT, see www.justice.govt.nz/justice-sector-policy/constitutional-issues-and-human-rights/human-rights/international-human-rights/cat/
United Nations Convention on the Elimination of all forms of Racial Discrimination (CERD)	CERD is the main international human rights treaty dealing with racial discrimination, and 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 about CERD, see www.justice.govt.nz/
United Nations Convention on the Rights of the Child (UNCROC)	UNCROC is a comprehensive human rights treaty that enshrines specific children's rights in international law. New Zealand ratified UNCROC on 6 April 1993. More information about UNCROC is available on the Office of the Children's Commissioner's website, at https://www.occ.org.nz/rights/
United Nations Convention on the Rights of Persons with Disabilities (CRPD)	The United Nations Convention on the Rights of Persons with Disabilities is an international human rights treaty that sets out what is required to implement existing human rights as they relate to disabled people. New Zealand ratified the CRPD on 25 September 2008. Information about the CPRD is available on the Office for Disability Issues website, at www.odi.govt.nz/united-nations-convention-on-the-rights-of-persons-with-disabilities/about-the-convention/
United Nations Declaration on the Rights of Indigenous Peoples	The UN Declaration on the Rights of Indigenous Peoples (the Declaration) is a comprehensive international human rights document on the rights of indigenous peoples. It 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 about the Declaration is available at www.tpk.govt.nz/en/a-matou-whakaarotau/te-ao-maori/un-declaration-on-the-rights-of-indigenous-peoples/
Young person (or young people), rangatahi	The Mental Health Act regards someone under the age of 17 as a child or young person.

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 Director of Area Mental Health Services as soon as practicable.

Guidance on the use of force under the Mental Health Act is provided in the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Crimes Act

In addition, there are a number of relevant sections in the Crimes Act 1961

Section 41 Prevention of suicide or certain offences

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

Section 48 Self-defence and defence of another

Everyone is justified in using, in defence of themselves or another, such force as, in the circumstances as they believe them to be reasonable to use.

Section 151 Duty to Provide the 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 necessaries is under a legal duty—

(a) to provide that person with necessaries; 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 of 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. URL: https://terauora.com/manaaki-mana-enhancing-and-mana-protecting-practice/(accessed 19 July 2022).

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. URL: https://www.hqsc.govt.nz/ourprogrammes/mental-health-and-addiction-quality-improvement/publicationsand-resources/publication/3600/ (accessed 1 August 2020).

Ministry of Health. 2020. Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington. Ministry of Health. URL: https://www.health.govt.nz/system/files/documents/publications/human-rights-mental-health-compulsory-assessment-treatment-act-1992-28august2020v2.pdf

Ministry of Health. 2020. Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington. Ministry of Health. URL: https://www.health.govt.nz/system/files/documents/publications/guidelines-mental-health-compulsory-assessment-treatment-act-1992-jan2021.pdf

Ngā Paerewa Health and Disability Services Standards (NZS 8134:2021) 6.4.6. URL: https://www.standards.govt.nz/shop/nzs-81342021/

Shalev, S. 2017. Thinking outside the Box? A Review of Seclusion and Restraint Practices in New Zealand, Human Rights Commission. URL: http://dx.doi.org/10.2139/ssrn.2961332

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