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SECLUSION IN MENTAL HEALTH: A BILL OF RIGHTS ANALYSIS

Submitted for the LLB (Honours) Degree

Faculty of Law

Victoria University of Wellington

2018

Abstract

Seclusion has been adopted for decades in mental health facilities in New Zealand to manage patients that are aggressive or exhibiting otherwise disturbing behaviour. Medical evidence proves that seclusion is not conducive to treatment and causes further psychological damage to patients. The recent case on Ashley Peacock, an autistic mentally unwell man who was secluded for eight years, attracted significant public attention and placed pressure on health authorities to improve seclusion standards. Using the test formulated by the Court of Appeal in Moonen v Film and Literature Board of Review, this paper establishes that seclusion is inconsistent with s 9 of the New Zealand Bill of Rights Act 1990 (NZBORA) that protects against cruel and disproportionately severe treatment. Furthermore, seclusion cannot be justified in a free and democratic society per s 5 of NZBORA. There are clear alternatives to seclusion that are more therapeutic but still achieve Parliament's objective of protecting others from harm. To bring seclusion more in line with NZBORA, this paper suggests the legislation can be reformed to define minimum standards of seclusion rooms and minimum entitlements for patients. Ultimately, this paper concludes that the Government must prioritise developing a more rights-consistent seclusion in all DHBs.

Key words

Seclusion, Mental Health (Compulsory Assessment and Treatment) Act 1992, New Zealand Bill of Rights Act 1990, ss 9 and 5, Moonen.

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I Introduction

Imagine a patient suffering from a mental illness, requiring extra care and attention. In a moment of distress, the patient becomes overwhelmed, unable to control their reactions and emotions. To manage the situation, the responsible clinician confines them to a small, cell-like room, without their consent, for an undefined period of time. The room contains no means of communication and the patient is not allowed visitors. There are no toilet facilities and the only piece of furniture is a plastic-covered mattress on a linoleum floor. The patient is locked inside and cannot leave unless deemed appropriate by staff.

The scenario just described is formally known as 'seclusion' and is provided for by s 71(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.[1] Left undefined in the Act, seclusion includes any practice whereby a patient is confined or isolated from others by being locked alone in a room with nursing staff monitoring their every movement.[2] Under s 71(2), clinicians are authorised to seclude patients for as long as necessary for the "care and treatment" of the patient or the "protection" of other patients.[3] Seclusion not only grossly interferes with fundamental freedoms but is also seen by many as a form of punishment as opposed to an effective treatment method.[4] An overwhelming majority of patients view seclusion as "profoundly negative" and only a small number of patients report the practice as being helpful to recovery.[5]

The recent media coverage on Ashley Peacock, a 40-year old autistic, intellectually disabled and mentally unwell man, threw the use of seclusion on mental health patients

[1] The Intellectual Disability (Care and Rehabilitation) Act 2003, s 61 also provides for seclusion.
[2] Human Rights Commission *Human Rights and Seclusion in Mental Health Services* (June 2008) at 6.
[3] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 71(2).
[4] Tom Meehan, Catherine Vermeer and Carol Windsor "Patients' perception of seclusion: a qualitative investigation" (2000) 31 Journal of Advanced Nursing 370 at 373.
[5] Te Pou o te Whakaaro Nui *Variation in DHB seclusion rates* (August 2017) at 8.

into the public eye.[6] By 2016, Ashley had been living in a seclusion room for approximately five and a half years, in the Capital & Coast District Health Board's Tawhirimatea Unit.[7] In February 2016, Chief Ombudsman Peter Boshier, recommended that as a matter of urgency, more appropriate accommodation be found for Ashley in the community.[8] However, Ashley was not released until August 2018.[9]

Intuitively, when one hears of seclusion, a myriad of human rights issues spring to mind. The secluded patient is deprived of the ability to control the most basic aspects of everyday life. This stripping away of individual autonomy is not only highly restrictive, but is also degrading. Section 9 of the New Zealand Bill of Rights Act 1990 (NZBORA) protects against "cruel, degrading, or disproportionately severe treatment" by the Government or bodies performing a public function. New Zealand legislation should be consistent with the rights contained in NZBORA, unless there are compelling justifications otherwise.[10] It is questionable whether s 71 of the Mental Health (Compulsory Assessment and Treatment) Act, that provides for seclusion, is consistent with NZBORA.

The United Nations has expressed serious human rights concerns about New Zealand's use of seclusion on multiple occasions. Seclusion is plainly at odds with art 14 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), ratified by New Zealand in 2008.[11] Article 14 instructs state parties to ensure that persons with disabilities can enjoy "the right to liberty and security" on an equal basis with others and are protected from unlawful or arbitrary deprivation of their liberty.[12] In its May 2014 report on New

[6] Kirsty Johnston "Autistic man locked in isolation for five years: 'He's had everything stripped from him'" *The New Zealand Herald* (online ed, Auckland, 16 June 2016) at 1.

[7] At 1.

[8] Peter Boshier *Report on an unannounced visit to Tawhirimatea Unit Under the Crimes of Torture Act 1989* (Office of the Ombudsman, February 2016) at 11.

[9] Kirsty Johnston "At last: Ashley Peacock to be released from cell-like room" *The New Zealand Herald* (online ed, Auckland, 6 August 2018) at 1.

[10] Legislative Design and Advisory Committee *Legislation Guidelines* (March 2018) at 32.

[11] Ministry of Justice "Convention on the Rights of Persons with Disabilities" (19 December 2017) <www.justice.govt.nz>.

[12] United Nations Convention on the Rights of Persons with Disabilities, 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008), art 14.

Zealand's compliance with the UNCRPD, the United Nations pressed New Zealand to take immediate steps to eliminate the use of seclusion in medical facilities.[13] Additionally, the United Nations Committee Against Torture (UNCAT) in their 2015 report, criticised New Zealand for the "excessive use of seclusion in mental health facilities" for purposes of "punishment, discipline and protection".[14] The Committee highlighted that Māori are more likely to be secluded as well as those with learning disabilities or mental illness.[15] Several recommendations were made including limiting the use of seclusion as a method of "last resort", prohibiting seclusion in "all health-care institutions" and conducting comprehensive investigations into any allegations concerning ill-treatment.[16]

Following criticism by the United Nations, the Government highlighted that the Ministry of Health's 2011 annual report on mental health statistics indicated that seclusion rates had fallen to 14 per cent.[17] Although this figure appears reasonably low, New Zealand still has a long way to go before seclusion is eliminated. The Government has implemented policy initiatives with the aim of reducing seclusion rates in recent years. Most notably, the Government has adopted the "Six Core Strategies checklist" from the United States, proven to reduce seclusion rates.[18] These strategies target various areas including leadership, data analysis, workforce development, alternative treatment methods and debriefing techniques, that can collectively reduce seclusion rates.[19] This initiative also highlights the importance of involving the wider community and those that have personal experiences with recovery in discussions around seclusion reduction.[20]

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[13] Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of New Zealand* CRPD/C/NZL/CO/1 (October 2014) at 4.

[14] Committee Against Torture *Concluding observations on the sixth periodic report of New Zealand* CAT/C/NZL/6 (May 2015) at 5.

[15] At 5.

[16] At 6.

[17] Committee Against Torture *Considerations of reports submitted by States parties under article 19 of the Convention pursuant to the optional reporting procedure: New Zealand* CAT/C/NZL/6 (March 2014) at 49.

[18] Te Pou o te Whakaaro Nui "The Six Core Strategies checklist" <www.topou.co.nz>.

[19] Te Pou o te Whakaaro Nui *Six Core Strategies checklist: New Zealand adaptation* (October 2013) at 3.

[20] At 15.

Another policy initiative, "Zero Seclusion", was announced in 2018 by Te Pou o te Whakaaro Nui and the Health Quality & Safety Commission (HQSC).[21] This initiative aims to eliminate seclusion by 2020 through applying evidence-based interventions that have eliminated seclusion elsewhere, supporting District Health Boards (DHBs) in implementing the Six Core Strategies checklist and engaging with the community.[22] However, despite these initiatives, seclusion rates are still as high as 23.3 per cent in some DHBs.[23] Perhaps policy initiatives are not enough and this issue needs to be tackled through legislative reform.

With reference to Ashley Peacock's case, this paper applies the test established by the Court of Appeal in *Moonen v Film and Literature Board of Review (Moonen)* to analyse whether seclusion under s 71 is consistent with NZBORA. This paper supports the Ombudsman's conclusions that seclusion, particularly in the case of Ashley Peacock, constitutes cruel and degrading treatment, is inconsistent with s 9 of NZBORA and cannot be justified by s 5. Furthermore, this paper discusses the scope for legislative reform in making seclusion more rights-consistent, improving the experience of seclusion for patients. Seclusion as it stands now, is degrading, traumatising and psychologically damaging.[24] To improve New Zealand's mental health practices and avoid criticism from the international community, the current Government must prioritise ameliorating seclusion standards.

[21] Health Quality & Safety Commission "Why eliminating seclusion by 2020 is an aspirational goal" (27 February 2018) <www.hqsc.govt.nz>.

[22] Te Pou o te Whakaaro Nui *Zero seclusion: towards eliminating seclusion by 2020* (2018) at 2.

[23] Te Pou o te Whakaaro Nui, above n 5, at 14.

[24] Mental Health Commission *Seclusion in New Zealand Mental Health Services* (April 2004) at 7.

II Case study: Ashley Peacock

A Overview

40-year-old Ashley Peacock suffers from a neurodevelopmental disability, autism and schizophrenia.[25] He is described as having a "goofy grin" and a strong love for animals.[26] Due to his condition, Ashley struggled during his school years and was unable to hold a stable job. His behavioural issues escalated over time and in 2003, his parents decided to place him in a care facility for people with intellectual disabilities.[27] Here, Ashley began his struggle through the health system. From residential care for the intellectually disabled, Ashley was moved to hospital to treat his psychosis. At this point, his compulsory treatment order was made "indefinite".[28] He was then subjected to 15 months in a seclusion room at the Henry Bennett Centre in Waikato, before it was decided that Ashley needed a service tailored to his "complex needs".[29] Ideally, this would be one that incorporated both disability and mental health services. However, no such facility was available, resulting in Ashley being transferred to the Capital & Coast District Health Board's Tawhirimatea Unit.[30]

In 2010, he was again placed in a seclusion room, under s 71 of the Mental Health (Compulsory Assessment and Treatment) Act due to his tendency to occasionally "lash out" at others.[31] Ashley's seclusion room resembled a prison cell, being only three by four metres and featuring one blocked off window. The room was practically empty, with only one plastic covered mattress, a small pile of clothing, a bottle for urine and a couple of Garfield comics.[32] There are no toilet facilities nearby and sometimes patients must resort

[25] The Office of the Ombudsman *Update from the Office of the Ombudsman: Chief Ombudsman Peter Boshier's address to the Mental Health Nurses Section of the New Zealand Nurses Organisation* (August 2017) at 4.
[26] Johnston, above n 6, at 1.
[27] At 1.
[28] At 1.
[29] At 1.
[30] At 1.
[31] At 1.
[32] At 1.

to using cardboard receptacles.[33] Ashley was allowed outdoors for only ninety minutes a day, closely monitored by staff. At the time, the intention was to keep him and others safe until his mental state improved enough for him to be transferred to community care.[34] However, Ashely's condition only deteriorated under seclusion, his mental health worsened, he gained weight and his assaults on staff only increased.[35]

In 2017, Ashley's parents presented a petition signed by 5,195 people calling for him to be released before the Health Select Committee in Parliament.[36] Subsequently, health authorities confirmed that Ashley would be released but the process may take up to six months.[37] Ashley was finally released, over a year later, in August 2018.[38] The process was excruciatingly slow and between 2017 and 2018, Ashley's condition deteriorated further. In early 2018, Ashley suffered two black eyes without any explanation from health authorities and was given the wrong medication, resulting in a trip to the hospital.[39]

B Ombudsman

The Office of the Ombudsman attempted to intervene many times over the years. The Optional Protocol to the Convention Against Torture (OPCAT) Inspectors were notified of Ashley in September 2011, following an unannounced inspection of the Tawhirimatea unit.[40] They expressed serious concerns and urged the Capital & Coast District Health Board (CCDHB) to find more suitable accommodation for Ashley.[41] The following year,

[33] Boshier, above n 8, at 12.

[34] Johnston, above n 6, at 1.

[35] At 1.

[36] New Zealand Herald "Ashley Peacock to be released from mental health unit" *The New Zealand Herald* (online ed, Auckland, 22 March 2017).

[37] Talia Shadwell "Long-term mental health patient Ashley Peacock to be released into the community" *Stuff New Zealand* (online ed, Auckland, 22 March 2017).

[38] Johnston, above n 6, at 1.

[39] Kirsty Johnston "Autistic man Ashley Peacock remains locked up a year on" *The New Zealand Herald* (online ed, Auckland, 21 May 2018).

[40] Ombudsman, above n 25, at 4.

[41] At 4.

in June 2012, OPCAT Inspectors conducted a follow-up visit and found Ashley still living in the seclusion room.[42] In February 2016, the OPCAT team conducted yet another unannounced visit to the Tawhirimatea unit and again found Ashley to be living in the same seclusion room.[43]

In the report following the 2016 visit, Chief Ombudsman Peter Boshier described Ashley's living conditions as "cruel, inhuman or degrading" under the United Nations Convention Against Torture.[44] The report highlighted that health authorities were taking a "punitive" as opposed to a therapeutic approach.[45] The Office of the Ombudsman again, as a matter of urgency, recommended that Ashley be moved to more suitable accommodation.[46] The report emphasised this same recommendation had been made on two previous occasions and progress had been "excruciatingly slow".[47] It was made clear that the CCDHB should ensure that a situation like Ashley's never arises again.[48]

As nothing had been done since the release of the report, the Office wrote to the CCDHB in June 2017, stating that Ashley's situation was "highly unsatisfactory" and action needed to be taken immediately.[49] Peter Boshier recognised people may have very complex needs that can be difficult to accommodate, but argued that a "civilized society" should treat the most vulnerable "humanely and with dignity", something that was not done in Ashley's case.[50]

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[42] At 4.

[43] At 4.

[44] Kirsty Johnston "Cruel, inhumane: Ombudsman's report on Ashley Peacock's living conditions" *The New Zealand Herald* (online ed, Auckland, 18 June 2016).

[45] Kirsty Johnston "Torture inspectors uncover 'cruel, degrading' care in hospitals" *The New Zealand Herald* (online ed, Auckland, 18 July 2016).

[46] Boshier, above n 8, at 6.

[47] At 11.

[48] At 11.

[49] Ombudsman, above n 25, at 4.

[50] New Zealand Herald "NZ Herald editorial: The troubling case of Ashley Peacock" *The New Zealand Herald* (online ed, Auckland, 22 May 2018).

To gain a comprehensive picture of seclusion generally, it is important to understand the legislative landscape under which Ashley was secluded. It is in the context of this legislative landscape that Ashley's case will be examined, to determine whether seclusion is consistent with NZBORA.

III Legislative Landscape

The Mental Health (Compulsory Assessment and Treatment) Act 1992, under which Ashley was secluded, is the primary piece of legislation that provides for seclusion of mental health patients. The Seclusion Guidelines, released in 2009, are particularly relevant to Ashley's seclusion events from 2010 onwards. While the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 also provides for seclusion, the focus of this paper is on the particular legislative framework applied in Ashley's case.[51]

A Mental Health (Compulsory Assessment and Treatment) Act 1992

Ashley was secluded under s 71(2) of the Mental Health (Compulsory Assessment and Treatment) Act.[52] Seclusion should only be employed when "necessary" for the treatment of the patient or the protection of other patients.[53] Seclusion can only be used if authorised by "the responsible clinician".[54] Nurses or other health professionals can place patients in seclusion in emergency situations, provided they inform the responsible clinician at the next available opportunity.[55] Furthermore, the "duration and circumstances" of each seclusion episode must be recorded in a register.[56]

[51] Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 60.

[52] Hilary Stace "Mental disorder, autism and human rights" (18 October 2016) Briefing Papers <www.briefingpapers.co.nz>.

[53] Mental Health (Compulsory Assessment and Treatment) Act, s 71(2)(a).

[54] Section 71(2)(c).

[55] Section 71(2)(d).

[56] Section 71(2)(e).

Despite the recognition that seclusion should only be used in "high risk" situations where there are no safer alternatives available, s 71(2) has been engaged in an unsettlingly large number of cases.[57] From October to December 2006, the seclusion rate was at 16.1 per cent.[58] It is particularly noteworthy that Māori were more likely to be secluded than any other ethnic group.[59] Between 2009 and 2016, the total number of secluded patients decreased by 25 per cent, exhibiting a steady decline over seven years.[60] However, upon closer examination, seclusion rates increased by 6 per cent between 2015 and 2016.[61] Furthermore, even in 2016, Māori were still highly susceptible, being 4.8 times more likely to be placed under seclusion.[62] These statistics suggest that perhaps the legislation does not adequately underscore the severity of seclusion, allowing it to be used in more circumstances than is justified and necessary.

In an attempt to reduce seclusion rates and encourage better seclusion standards in DHBs, the Ministry of Health released Seclusion Guidelines under the Act in 2009.[63] These guidelines expand on s 71 and provide a more comprehensive framework for seclusion.[64]

B Seclusion Guidelines

The guidelines define seclusion and important considerations that should be taken into account before seclusion is employed.[65] Amongst these considerations are the "potential physical and psychological" effects on the patient, whether or not alternative methods have

[57] Introduction to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (looseleaf ed, Thompson Reuters) at [MHIntro.03].

[58] At [MHIntro.03].

[59] At [MHIntro.03].

[60] Ministry of Health *Office of the Director of Mental Health Annual Report 2016* (December 2017) at 33.

[61] At 34.

[62] At 38.

[63] Ministry of Health *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (February 2010) at iii.

[64] The Intellectual Disability (Care and Rehabilitation) Act 2003, s 60(3)(b) imposes a statutory obligation to comply with the seclusion guidelines. This obligation is not present in the Mental Health (Compulsory Assessment and Treatment) Act 1992.

[65] Ministry of Health, above n 63, at 1.

been attempted, the patient's "specific cultural needs" and the safety of patients and others during seclusion.[66]

Appendix one is particularly noteworthy as it outlines circumstances where seclusion is appropriate. Clinicians may resort to seclusion to control harmful behaviour that cannot otherwise be controlled, when a patient's behaviour is disturbed due to "marked agitation, thought disorder, hyperactivity or grossly impaired judgment", to minimize disruption caused by external stimuli for a "highly aroused" patient and to "prevent harmful or destructive behaviour".[67] Under certain circumstances, seclusion should be exercised with "extreme caution", such as when there is "no demonstrable psychiatric illness" or a likelihood of self-harm.[68]

Appendix one further provides minimum standards of seclusion rooms. They must have "adequate light, heat and ventilation", means of easy observation that enable the patient to see the "head and shoulders of the observer", means for the patient to "call for attention" and fixed fittings and furnishings to avoid risk of harm.[69] Other desirable (but not absolutely necessary) features include, a pleasant but minimally-stimulating environment, no deprivation of the patient's personal items and nearby access to bathroom facilities.[70]

None of the "desirable" features outlined in the Seclusion Guidelines were present in Ashley's case. Ashley's seclusion room contained the bare minimum. By way of furniture, the room contained only one plastic-covered mattress.[71] The room did not have nearby access to bathroom facilities and absolutely could not be classed as being "pleasant". The only personal belongings in Ashley's room were a few clothing items and a couple of Garfield comics.[72]

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[66] At 1.
[67] At 5.
[68] At 5.
[69] At 5.
[70] At 6.
[71] Johnston, above n 6, at 1.
[72] At 1.

At first glance, the Seclusion Guidelines supplement s 71 to reduce seclusion rates. The guidelines highlight the few instances where seclusion is appropriate. Risk factors are underscored which should be considered before, during and after seclusion. Despite these clarifications, seclusion is still being employed in circumstances that are highly unsatisfactory, as illustrated by Ashley's case.

Seclusion is surrounded by human rights concerns. NZBORA is the primary piece of legislation protecting fundamental rights from contravention by Government or bodies performing public functions.[73] As a body performing a public function, the CCDHB falls under s 3(b) of the Act. Therefore, NZBORA is applicable to Ashley's case.

IV New Zealand Bill of Rights Act 1990 (NZBORA)

As identified by the UN and the Ombudsman, seclusion breaches fundamental human rights. These rights are enshrined in NZBORA as well as the UNCRPD and the UNCAT. The primary rights affected by seclusion are contained in ss 9, 11 and 22 of NZBORA. The focus of this paper will be on s 9, the right "not to be subjected to torture or cruel treatment", as this is most relevant to Ashley's case.[74]

A Section 9—Right Not to be Subjected to Torture or Cruel Treatment

Chief Ombudsman Peter Boshier expressed that Ashley's living conditions were cruel, inhuman and degrading, suggesting his rights under s 9 were breached.[75] Section 9 states that "everyone has the right not to be subjected to torture or to cruel, degrading, or

[73] New Zealand Bill of Rights Act 1990, s 3.

[74] Section 9.

[75] Ombudsman, above n 25, at 4.

disproportionately severe treatment".[76] Often, seclusion is exercised in a manner that is cruel and degrading both objectively and in the eyes of the patient.[77]

The UN considers seclusion in New Zealand to be a breach of art 16 of the UNCAT, amounting to "cruel, inhuman or degrading" treatment that does not amount to torture under art 1.[78] It follows that seclusion also impinges s 9, as both s 9 and art 16 concern cruel and degrading treatment. Notably, the Mental Health Foundation admits that seclusion limits rights under s 9 and that seclusion practices are "difficult or impossible to justify".[79]

B Sections 11 and 22

Ashley's right to refuse medical treatment under s 11 of NZBORA was undoubtedly breached, as s 59(4) of The Mental Health (Compulsory Assessment and Treatment) Act states that treatment may be given "without the patient's consent".[80] The Act deliberately overrides s 11 due to the potential harm caused by not providing compulsory treatment.[81]

As Ashley was forced to reside in unpleasant, confining conditions that limit his movements, his rights under s 22 of NZBORA are also engaged. Section 22 protects the liberty of individuals and provides that everyone has the right not to be "arbitrarily" detained.[82] A compulsory order for seclusion should not be made unless the "need to protect the public" is great enough to justify interference with the patient's liberty under s

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[76] New Zealand Bill of Rights Act, s 9.

[77] Peter Hodgkinson "The Use of Seclusion" (1985) 25 Med. Sci. & L. 215 at 219.

[78] United Nations Convention Against Torture, 1465 UNTS 85 (open for signature 4 February 1985, entered into force 26 June 1987), art 16.

[79] Mental Health Foundation *Legal Coercion Fact Sheets* (2016) at 21.

[80] Mental Health (Compulsory Assessment and Treatment) Act, s 59.

[81] Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (November 2012) at 69. The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 62 also plainly infringes s 11 by stating a care recipient can receive treatment and be subject to seclusion without their consent.

[82] New Zealand Bill of Rights Act, s 22.

22 of NZBORA.[83] The High Court in *J v Attorney-General* highlighted that a compulsory care order should only be made if it is the "least restrictive" response to satisfy the need to protect the community.[84] Furthermore, the weight given to a patient's liberty interest increases the longer a patient has been subject to a compulsory order.[85]

As Ashley was living in a seclusion room for eight years, significantly greater weight should be given to his liberty interests over any potential threat to the community. Confining Ashley to a seclusion room is hardly the least restrictive response. Ashley could have been provided with a room that was less sensory stimulating, but still reasonably pleasant. He could have been given other activities to lift his mood and keep him occupied. It is difficult not to reach the conclusion that Ashley's rights under s 22 have been breached.

Although the rights contained in ss 11 and 22 of NZBORA are relevant to seclusion, s 9 is the critical right to examine. In describing Ashley's living conditions as "cruel, inhuman or degrading", potential breaches of rights under s 9 have attracted the most criticism from the Ombudsman. To determine the extent to which seclusion under s 71 impinges on s 9, the test established by the Court of Appeal in *Moonen* will be applied.[86]

[83] *J v Attorney General* [2018] NZHC 1209 at [172].

[84] At [172].

[85] At [172].

[86] The *Moonen* test is more appropriate than the test articulated by the Supreme Court in *Paul Rodney Hansen v The Queen* [2007] 3 NZLR 1 [*Hansen*] at [58]-[62]. In *Hansen*, the provision in question was plain and other interpretations were not open to the Court. Therefore, the Court reasoned that it was not necessary to evaluate alternative meanings under s 6 of NZBORA. In *Moonen*, there was no one meaning that could be identified as clearly intended by Parliament and the provision in question granted considerable discretion. Section 71 can have a range of meanings and gives health authorities a large amount of discretion in determining whether seclusion is "necessary" in the circumstances. Therefore, the *Moonen* test is more appropriate here.

V Moonen Test

The *Moonen* test comprises five steps. Firstly, the scope of the relevant right or freedom must be determined. Secondly, different meanings that are reasonably open on the words of the provision in question should be identified.[87] If there is only one meaning "properly open", that meaning must be adopted per s 4 of NZBORA.[88] However, if there are multiple meanings available, the third step is to identify the meaning that limits the right or freedom in question the least.[89] This meaning should be adopted, per s 6.[90] Taking this meaning, the fourth step is to evaluate the extent to which the right or freedom is limited.[91] Finally, an analysis is undertaken to ascertain whether such a limitation can be justified per s 5.[92] If the provision is inconsistent with s 5, Courts must adopt the natural meaning of the provision per s 4 of NZBORA despite the inconsistency.[93]

Section 71 is the empowering provision. Thus, if s 71 is inconsistent with NZBORA, the guidelines will also be inconsistent as a consequence. If an inconsistency is found within the empowering provision, Parliament must alter the legislation to bring seclusion more in line with NZBORA. Simply amending the guidelines will not have this affect.

A The Scope of s 9

On its face, s 9 is fairly broad, covering not only extreme cases of torture or cruel treatment but also other forms of degrading or disproportionately severe treatment. Justice Ronald Young in the High Court in *Taunoa v Attorney General* considered s 9 had an inherent hierarchy, with cruel treatment sitting at the top.[94] In the Court of Appeal, cruel treatment

[87] *Moonen v Film and Literature Board of Review* [2000] 2 NZLR 9 [*Moonen*] At [17].
[88] At [17].
[89] At [17].
[90] At [18].
[91] At [18].
[92] At [18].
[93] At [19].
[94] *Taunoa v Attorney-General* (2004) 7 HRNZ 379 at [272].

under s 9 was considered to be any treatment that shocked the conscience of the community, degrading treatment involved "gross humiliation or debasement" and disproportionately severe treatment was such that would "outrage standards of decency".[95] This can be conceptualised as a spectrum, with cruel treatment on one end and disproportionately severe treatment on the other.

Chief Justice in the Supreme Court added to this assessment by stating that a failure to treat a person with "humanity", or treatment that could be described as "inhuman", would also amount to a breach of s 9.[96] American case law is also helpful in ascertaining the scope of s 9. Brennan J in *Furman v Georgia* considered that the infliction of "unnecessary" severe treatment, when less severe alternatives would serve the purpose, would be a breach of the Eighth Amendment, analogous to a breach of s 9.[97]

Section 9 should be interpreted "generously and purposively", therefore it is important to refer to art 7 of the International Covenant on Civil and Political Rights, on which s 9 is based.[98] Article 7 aims to protect the dignity and the "physical and mental integrity" of individuals.[99] Thus, treatment that constitutes a threat to dignity or physical and mental integrity falls within the scope of s 9.

Overall, the scope of s 9 is broad, covering a spectrum of circumstances. At the lower end of the spectrum, s 9 covers disproportionately severe treatment that would "outrage standards of decency", including unnecessarily severe treatment when less severe alternatives are available. Degrading treatment that involves "gross humiliation or debasement" is toward the middle of the spectrum. Finally, cruel treatment that shocks the conscience is at the higher end of the spectrum. Inhuman treatment permeates through all circumstances covered by s 9. Treatment that threatens an individual's dignity or physical

[95] *Taunoa & Ors v Attorney-General & Anor* [2008] 1 NZLR 429 at [64].

[96] At [7].

[97] *Furman v Georgia* 408 US 238 (1972) at 279.

[98] *Taunoa & Ors,* above n 95, at [76].

[99] UN Human Rights Committee *CCPR General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)* (10 March 1992) at 1.

or mental integrity falls under s 9, to the extent that it can be classified as disproportionately severe, degrading or cruel treatment. Ashley's circumstances were regarded as cruel, degrading and inhuman, undoubtedly falling within the scope of s 9.

B Meaning Open on the Words of the Provision

As previously discussed, s 71(2)(a) states that seclusion shall only be used for as long as is "necessary" for the "care or treatment of the patient, or the protection of other patients".[100] The circumstances where seclusion is necessary carry some ambiguity. Appendix One of the Seclusion Guidelines offers some guidance by outlining circumstances where seclusion is appropriate.

According to the Seclusion Guidelines, seclusion is appropriate to control harmful or disturbing behaviour that poses a threat to the patient or others and cannot be controlled by alternative measures.[101] The word "harmful" suggests the behaviour could potentially physically harm the patient or others, whereas "disturbance of behaviour" may cover situations apart from the threat of physical harm.

Overall, the guidelines imply there is a range of situations where seclusion may be appropriate, from circumstances where the patient is exhibiting aggressive or violent behaviour that is physically harmful to merely behaviour that disrupts the treatment of other patients. The interpretation of the words "necessary" and "protection" in s 71(2)(a) inform the range of circumstances covered by the guidelines.

If "protection" in s 71(2)(a) refers to protection from physical harm, it is likely that seclusion is only considered "necessary" in circumstances where the patient is violent or aggressive. However, "protection" could also refer to protecting the overall treatment of the patient or other patients, meaning seclusion can be considered "necessary" in

[100] Mental Health (Compulsory Assessment and Treatment) Act, s 71(2)(a).

[101] Ministry of Health, above n 63, at 5.

circumstances where the patient exhibits disturbing behaviour, but does not pose a physical threat.

Ultimately, there is a spectrum of meanings that could be afforded to s 71(2). At one end of the spectrum, seclusion is "necessary" when the patient is exhibiting violent or aggressive behaviour that could be harmful to themselves or others. This may include situations where the patient is attempting to commit suicide or lashing out at other patients or staff.[102] On the other end of the spectrum, seclusion may be "necessary" when the patient is exhibiting disturbing behaviour as a result of hyperactivity or impaired judgement, that can interfere with the treatment of other patients. For example, the patient could be loud, agitated or offensive. In between these two extremes lie situations where the patient threatens to harm themselves or others, but does not carry out actions in fulfilment of that threat. All of these meanings are reasonably open on the words of the provision.

In Ashley's case, Ashley was secluded due to his tendency to "lash out" at staff members.[103] In response to the Ombudsman report, the CCDHB stated that Ashley was placed in the seclusion room to manage the "on-going issues with unpredictable acts of violence".[104] According to the General Manager of Mental Health, Addiction and Disability Services, Ashley "randomly and regularly" assaulted staff and others on hundreds of occasions whilst in the Tawhirimatea Unit.[105] Therefore, in Ashley's case, the meaning afforded to "necessary" would be on the higher end of the spectrum, where the patient exhibits violent or aggressive behaviour.

[102] Alice Keski-Valkama and others "The reasons for using restraint and seclusion in psychiatric inpatient care: A nationwide 15-year study" (2010) 64 Nordic Journal of Psychiatry 136 at 138.

[103] Johnston, above n 6, at 1.

[104] Boshier, above n 8, at 27.

[105] At 27.

C The Meaning that Constitutes the Least Infringement on the Right

Adopting the meaning that deems seclusion "necessary" only in situations where the patient exhibits violent behaviour that can cause physical harm, constitutes the least infringement on s 9. Although the practice of seclusion is inherently degrading to the same extent regardless of the reason why the patient is secluded, adopting this meaning will narrow the circumstances where seclusion is considered appropriate. Doing so will result in s 9 being engaged in fewer cases overall.

Ashley was secluded as a result of his random assaults on staff, therefore this meaning of "necessary" under s 71 was likely to have been adopted by health authorities in Ashley's case. As this meaning is the least infringing on s 9, it must be preferred over any other meaning according to s 6 of NZBORA.[106]

D The Extent to which s 71 Interferes with s 9

Seclusion under s 71 interferes with an individual's right not to be subjected to cruel, degrading or disproportionate treatment to a significant extent. In Ashley's case, his seclusion room was completely bare, with no view to the outside world, no bathroom facilities and very few possessions.[107] He was only allowed outside for 90 minutes a day.[108] At one point in time, Ashley was only allowed outside for thirty minutes a day, for two and a half years.[109]

Seclusion is short of physical torture and is more inhuman and degrading than it is "cruel", meaning that it likely falls on the lower end of the spectrum of treatment that can be caught by s 9. Notwithstanding, focussing solely on the "degrading and disproportionately severe

[106] New Zealand Bill of Rights Act, s 6.

[107] Johnston, above n 6, at 1.

[108] At 1.

[109] At 1.

treatment" component of s 9, seclusion undoubtedly constitutes a significant interference with the right. The treatment endured by Ashley is clear evidence of this interference.

VI Section 5 Analysis

After having established that s 71 of the Act constitutes a substantial breach of the rights contained in s 9, it is necessary to analyse whether such a breach can be "demonstrably justified" in a free and democratic society per s 5. A further test for this analysis was laid out in *Moonen*.[110] In order to be consistent with s 5, the limitation on s 9 must be "justifiable in light of [its] objective".[111] This involves an analysis of Parliament's objective and whether or not there is a "rational connection" between seclusion under s 71 and achieving the objective. Furthermore, to be consistent with s 5, seclusion must achieve Parliament's objective in a manner that constitutes the least possible interference with s 9.[112] In other words, if Parliament's objective can be achieved through means that are more rights-friendly, seclusion cannot be justified by s 5.

A The Objective of Seclusion Under s 71

Section 71 suggests Parliament's objective is two-fold, to protect the patient from harming themselves and to protect others from being harmed. This is evidenced by s 71(2)(a), where seclusion can only be used when "necessary" for the protection of other patients.[113] Furthermore, the circumstances where seclusion is appropriate under the Seclusion

[110] See *Moonen,* above n 87, at [18]-[19] where the factors taken into account when determining whether a limitation can be justified under s 5 are outlined. These factors include Parliament's intended objective of the provision, the importance of the objective and whether the means by which the objective is achieved is proportionate to its importance. There must be a "rational relationship" between the objective and the means used to achieve it. There must "as little interference as possible" with the rights or freedoms affected. All issues in any given case must be considered, whether "social, legal, moral, economic, administrative, ethical or otherwise".

[111] *Moonen,* above n 87, at [18].

[112] At [18].

[113] Mental Health (Compulsory Assessment and Treatment) Act, s 71(2)(a).

Guidelines all involve circumstances where the patient's behaviour is harmful, destructive or disturbing.[114]

Parliament intends seclusion to be used as a last resort, when no other effective intervention is possible.[115] Section 71(2)(a) suggests that Parliament does not intend seclusion to be used for extended periods of time, as it should only be used for as long as necessary for the protection of other patients.[116] It is not apparent from the wording of s 71, or the seclusion guidelines, that the main objective of seclusion is to treat the individual patient.

Public safety is undoubtedly an important objective for Parliament and permeates through many pieces of legislation. For example, the purpose of the Health and Safety at Work Act 2015 is to secure the health and safety of workers through protecting workers against harm and minimising risks arising from work.[117] In some circumstances, protecting others from harm justifies limiting rights and freedoms.

B Is Seclusion Rationally Connected to its Objective?

Seclusion effectively removes an individual patient from a situation where they may be causing harm to themselves or others and forces them to an environment where they can no longer cause such harm. However, seclusion may also incite feelings of anger and aggression in the patient, increasing the likelihood of violence.[118] Therefore, although seclusion temporarily achieves the objective of protecting the patient and others from harm by removing the patient from the environment, it is not *rationally* connected to the objective in the long-run.

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[114] Ministry of Health, above n 63, at 5. See also the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 60 where seclusion can be used to prevent the patient from endangering themselves or others.

[115] Ministry of Health, above n 63, at iii.

[116] Mental Health (Compulsory Assessment and Treatment) Act, s 71(2)(a).

[117] Health and Safety at Work Act 2015, s 3.

[118] Mental Welfare Commission for Scotland *Good practice guide: The use of seclusion* (2014) at 11.

There is evidence that seclusion can aggravate the patient, making it more likely they will lash out in the future. For example, in Ashley's case, his assaults on staff increased after he was placed in seclusion.[119] Seclusion can result in a range of negative psychological effects on the patient including anxiety, panic, rage, poor impulse control and paranoia.[120] Therefore, it is conceivable that fear of being placed under seclusion, or the impact seclusion has had on the patient, may in fact be the reason for their lashing out. The secluded patient may consider they were "forced into" being aggressive because of how they were treated.[121] Patients that have experienced previous trauma such as physical assault or sexual abuse are more likely to be secluded.[122] For these patients, seclusion can result in "re-traumatisation", increasing the likelihood of PTSD (post-traumatic stress disorder).[123]

Notably, patients experience anger as a result of being secluded and may display violence toward objects in the seclusion room or their own possessions.[124] These feelings of anger are likely not conducive to achieving the objective of protecting the patient from themselves or protecting other patients. Patients often adopt harmful coping strategies while in seclusion, including "shouting, banging on the door" and "breaking objects".[125] These behaviours are inherently harmful to the patient. For example, Ashley suffers from disordered sensory perception and is unable to handle loud noises. Often the other patients in Ashley's unit can be very loud and disruptive, causing Ashley to lash out in turn.[126]

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[119] Johnston, above n 6, at 1.

[120] Dr Sharon Shalev *Thinking outside the box: A review of seclusion and restraint practices in New Zealand* (Human Rights Commission, April 2017) at 17.

[121] Mental Welfare Commission for Scotland, above n 118, at 11.

[122] Fiona Whitecross, Amy Seeary and Stuart Lee "Measuring the impacts of seclusion on psychiatry inpatients and the effectiveness of a pilot single-session post-seclusion counselling intervention" (2013) 22 International Journal of Mental Health Nursing 512 at 513.

[123] At 513.

[124] Dave Holmes, Suzanne L. Kennedy and Amélie Perron "The mentally ill and social exclusion: A critical examination of the use of seclusion from the patient's perspective" (2004) 25 Issues in Mental Health Nursing 559 at 570.

[125]At 571.

[126] Johnston, above n 6, at 1.

Ultimately, seclusion is a quick-fix and temporarily protects the patient and others by removing the patient from an environment where they can cause harm. However, considering the impact of seclusion on the patient and medical evidence, it is not *rationally* connected to the objective. Seclusion has negative effects on the psychological well-being of the patient and does not protect them from harm. Being placed in a seclusion room incites feelings of anger in the patient and can increase the likelihood of future behavioural incidents, meaning that in the long-run, seclusion does not protect others from harm.

C Does Seclusion constitute as Little Interference as Possible with s 9 to Achieve the Objective?

As previously discussed, seclusion under s 71 interferes with an individual's right not to be subjected to cruel, degrading or disproportionate treatment to a significant extent. Evidence indicates there are more empathetic and therapeutic alternatives to seclusion, or at least different methods of seclusion, that can still achieve the objective of protecting the patient and others from harm.

Health authorities could provide more activities for the secluded patient, such as walks and group therapy.[127] In Ashley's case, he was often denied requests of watching DVD's, going for a walk or even a cup of tea.[128] With nothing else to do, Ashley would resort to spending hours wiping the walls.[129] Providing Ashley with more opportunities to venture outside or engage in productive activities would have constituted less of an infringement on Ashley's rights and would likely have been more conducive to his treatment. In a psychiatric unit in Lancashire, England, patients were allowed weekly visits to the nearby zoo.[130] The results of this were overwhelmingly positive, and the incidence of aggression in the ward reduced

[127] Raija Kontio and others "Patient restrictions: Are there ethical alternatives to seclusion and restraint" (2010) 17 Nursing Ethics 65 at 70.

[128] Johnston, above n 6, at 1.

[129] At 1.

[130] Arokia Antonysamy "How can we reduce violence and aggression in psychiatric inpatient units?" (2013) BMJ Quality Improvement Reports at 1.

significantly.[131] A similar weekly activity could have been implemented in Ashley's case, increasing his freedom whilst achieving Parliament's objective of protecting him and others from harm.

Patients could also be more involved with their treatment, through having conversations with nursing staff or being consulted about how they would like to be treated.[132] The seclusion room could be changed to be more pleasant for the patient, as opposed to resembling a prison cell. Staff could be trained in other techniques to calm a patient down during a behavioural incident. For example, staff learnt that simply placing a hand on Ashley's arm can calm him down in most situations.[133]

Eliminating seclusion is achievable and does not necessarily correspond with a more dangerous environment for others. Seclusion is not used in psychiatric hospitals in Scotland and it is rarely employed in the United Kingdom.[134] In the United States, efforts to reduce or eliminate seclusion have resulted in decreased staff injuries and increased treatment satisfaction.[135] Te Pou o te Whakaaro Nui conducted an investigation into whether reducing seclusion leads to increase risk to staff safety. It was noted that various studies indicated that "seclusion reduction can be implemented without additional risk to staff safety".[136] A number of recommendations were provided, including more staff engagement and replacing seclusion rooms with "more sensory appealing areas".[137]

Ultimately, the evidence strongly suggests that less restrictive practices can be employed to achieve the objective of protecting others from harm. Patients do not need to be subjected to the degrading treatment that comes with seclusion but can have access to less coercive,

[131] At 1.

[132] Raija Kontio, above n 127, at 70.

[133] Johnston, above n 6, at 1.

[134] Human Rights Commission, above n 2, at 43.

[135] Dr Janice L. LeBel and others "Multinational Experiences in Reducing and Preventing the Use of Restraint and Seclusion" (2014) 52 Journal of Psychosocial Nursing and Mental Health Services 22 at 25.

[136] Te Pou o te Whakaaro Nui *Do seclusion reduction initiatives increase risk to staff safety* (June 2014) at 22.

[137] At 20.

more therapeutic experiences. Seclusion as it stands now, cannot be said to be justified in a free and democratic society. Developing less coercive alternatives to seclusion will not only impinge less on s 9 but will also better achieve Parliament's objective in the long-run. Recent policy initiatives suggest that the Government would agree with this conclusion and is serious about improving seclusion standards and reducing seclusion rates.

VII The Move Toward Zero Seclusion

The primary organisation responsible for developing seclusion reduction initiatives is Te Pou o te Whakaaro Nui, the national centre of evidence-based workforce development for the mental health, addiction and disability sectors in New Zealand. The two salient initiatives developed in recent years are the "Six Core Strategies" checklist and "Zero Seclusion".

The Six Core Strategies checklist was originally developed by the US National Association of State Mental Health Program Directors (NASMPHD) and has been adapted to suit New Zealand.[138] It was implemented in 2010 and a three-year development approach was agreed upon, with the goal of reducing seclusion rates each year until they reached zero.[139] The strategies target different areas that can collectively reduce seclusion rates. Target areas include leadership, data collection and use, workforce development, developing other approaches that assist patients with emotional self-management, reaching out to others who have personal experiences with seclusion and developing comprehensive "debriefing techniques" following seclusion events.[140]

In 2013, a retrospective study was undertaken in a 32-bed in-patient psychiatric unit that catered to adults aged 18 to 65, to analyse the impact of the implementation of the six core

[138] Te Pou o Te Whakaaro Nui "Six core strategies for reducing seclusion and restraint checklist" (15 August 2013) <www.tepou.co.nz>.

[139] Trish Wolfaardt "An evaluation of the efficacy of the six core strategies intervention to reduce seclusion and restraint episodes in an acute mental health unit." (BHSc (Hons) Dissertation, University of Auckland, 2013) at 18.

[140] Te Pou o te Whakaaro Nui, above n 138.

strategies.[141] Before implementation, the unit recorded 172 seclusion episodes.[142] This number reduced to 46 in the first-year post-implementation and only 2 episodes of seclusion were recorded in the second year.[143] Following implementation, staff attitudes toward seclusion also changed significantly. Staff had a greater understanding of the harmful effects of seclusion and were more open to alternative options.[144] These results indicate that the framework has the potential to significantly reduce seclusion rates without a corresponding increase in risk to the safety of staff and other patients. However, the original goal of reducing seclusion rates to zero within three years was not met. This outcome suggests that policy initiatives may not be enough and perhaps legislative reform is necessary.

The "Zero Seclusion" initiative was announced by Te Pou o te Whakaaro Nui and the Health Quality & Safety Commission (HQSC) in 2018.[145] The overarching objective is to eliminate seclusion by 2020.[146] The HQSC acknowledged that seclusion causes physical and emotional harm, contravenes basic human rights and is not aligned with "modern, evidence based, high quality care".[147] This initiative takes on a holistic approach, aiming to reduce seclusion through applying evidence-based interventions that have eliminated seclusion elsewhere, supporting DHBs in implementing the Six Core Strategies framework and engaging with the community.[148] However, the HQSC does acknowledge that the goal is "aspirational", suggesting it may not be achievable.[149]

While positive steps have been made in reducing seclusion, not all DHBs have benefitted from the new initiatives. In 2015, the average rate of seclusion across all DHBs was 7.7

[141] Trish Wolfaardt, above n 139, at 20.
[142] At 25.
[143] At 25.
[144] At 31.
[145] Health Quality & Safety Commission, above n 21, at 1.
[146] At 1.
[147] At 1.
[148] Te Pou o te Whakaaro Nui, above n 22, at 2.
[149] Health Quality & Safety Commission, above n 21, at 1.

per cent, however some DHBs had seclusion rates as high as 23.3 per cent.[150] Notably, the DHBs with higher seclusion rates had a higher proportion of Māori using their services.[151] Variation in seclusion rates may also be linked to the location and size of the units.[152] These results indicate that despite policy initiatives, seclusion is still very prevalent. Legislative reform may offer a more sustainable solution to reducing seclusion rates or improving the experience of seclusion for patients. Reforming s 71 of the Mental Health (Compulsory Assessment and Treatment) Act can result in changes in seclusion standards across the board, impacting all DHBs.

VIII Possibilities for Reform

As established, seclusion under s 71 of the Mental Health (Compulsory Assessment and Treatment) Act infringes s 9 of NZBORA and cannot be justified under s 5. As a consequence, the Seclusion Guidelines are also inconsistent with NZBORA. To rectify this inconsistency, Parliament must reform s 71. Currently, s 71 offers little guidance on what seclusion actually means or how it should be implemented. There are opportunities to reform both the legislation and the guidelines to ensure seclusion constitutes the least possible infringement to s 9 while still achieving its objective. Reform will also bring New Zealand more in line with obligations under the UNCRPD and UNCAT.

A Reforming s 71

There is scope to reform s 71 by adding two more subsections, focussing on the requirements of seclusion rooms and entitlements of secluded patients. Parliament has successfully targeted seclusion through legislative reform in the past, with regard to seclusion being employed in schools for discipline and behavioural management. In May

[150] Te Pou o te Whakaaro Nui, above n 5, at 14.
[151] At 15.
[152] At 20.

2017, the Education (Update) Amendment Act 2017 came into force.[153] Section 96A of the Act amended the Education Act 1989 to ban the use of seclusion in schools and early childhood services.[154] New Zealand's health system is not quite ready for a blanket legislative ban on seclusion. The main concern with a complete move away from seclusion is the lack of viable alternatives.[155] Other barriers to banning seclusion include lack of resources, poor facilities and lack of staff training on warning signs of aggression and other effective interventions.[156] However, legislative reform can be effective in improving seclusion standards whilst it is still in use.

In April 2017, the Human Rights Commission released a report by Dr Sharon Shalev, an international expert in solitary confinement and seclusion, outlining a number of recommendations to health authorities. These recommendations can and should be incorporated into the legislative framework.

Shalev's recommendations mainly focus upon improving the physical environment of seclusion rooms. Shalev contends that small changes to the patient's environment can "normalise" the experience and give some control back to the patient.[157] These changes include introducing basic, "tamper-proof" "safe furniture" to all seclusion rooms, allowing patients to keep low-risk personal belongings and providing patients with something productive to do inside the rooms. [158] Additionally, patient's should have access to "call-bells" so they can communicate with staff and seclusion rooms must include light switches and blind controls, unless there are "compelling and temporary" reasons not to have them.[159] The patient must also have free access to drinking water, without having to ask for

[153] Ministry of Education "Ed Act Update – The Education (Update) Amendment Act 2017" (24 August 2018) <www.education.govt.nz>.

[154] Education (Update) Amendment Act 2017, s 96A.

[155] Nursing Review "Safe alternatives to seclusion being sought, says mental health nurse leader" (11 July 2018) <www.nursingreview.co.nz>.

[156] The Royal Australian & New Zealand College of Psychiatrists *Position Statement 61 Minimising the use of seclusion and restraint in people with mental illness* (February 2016) at 3.

[157] Shalev, above n 120, at 59.

[158] At 59.

[159] At 59.

it.[160] Finally, introducing outdoor yards with stationary exercise equipment can also improve the experience of seclusion for the patient.[161]

Not all DHBs will have the resources necessary to incorporate all of these recommendations. Nevertheless, basic features including access to drinking water, light switches and call-bells, should be made compulsory requirements in the legislation. These requirements can be incorporated as a new subsection under s 71 with the heading 'seclusion room requirements'. Doing so ensures there is a statutory obligation on DHBs to ensure all seclusion rooms have at least these basic features.

Shalev further recommends that the Ministry of Health introduce "Minimum Entitlements" to patients in seclusion, similar to the Department of Corrections.[162] These entitlements should include exercise time, shower access, telephone and family visits.[163] Introducing a subsection on minimum entitlements under s 71 will ensure patients are not deprived of basic provisions whilst in seclusion and their autonomy is less restricted. Ensuring all secluded patients have at least these minimum entitlements can "mitigate the harms of seclusion" and create a more positive environment.[164]

Finally, s 71 should impose a statutory obligation on health authorities to comply with seclusion guidelines. [165] Doing so will result in more consistent seclusion practices between DHBs and a higher standard of care for all secluded patients.

[160] At 60.
[161] At 60.
[162] At 60.
[163] At 60.
[164] At 60.
[165] The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 60(3)(b) imposes an obligation to comply with seclusion guidelines.

B Reforming the Guidelines

To reinforce any amendments made to the legislation, the Seclusion Guidelines must also be amended. Some features classified as merely "desirable" features of seclusion rooms under Appendix One should be moved to be "minimum requirements". In particular, a "pleasant" environment, access to "toileting, washing and showering facilities" and means of orientation such as date and time should be made minimum requirements.[166]

To reduce the likelihood of prolonged seclusion events, ss 7.1 and 7.2 of the Seclusion Guidelines should be amended. Section 7.1 requires that the decision to end seclusion be made by two clinicians, in agreement with the responsible clinician.[167] This process can lead to delays if appropriate staff are not present.[168] Rather than requiring three clinicians to end a seclusion event, s 7.1 can be amended to require only two clinicians. Doing so will increase efficiency and ensure patients are not secluded for longer than necessary. Section 7.2 states that seclusion comes to an end if the patient is out of the seclusion room for more than an hour.[169] Consequently, staff may be discouraged from allowing secluded patients outside for longer than an hour, as doing so would result in a new seclusion event with more associated paperwork.[170] Section 7.2 should be amended in a manner that is less restrictive and encourages fresh air, exercise and engagement with staff for as long as possible.[171]

Reforming s 71 and the corresponding seclusion guidelines can collectively improve seclusion standards across the board, ensuring cases such as Ashley's do not arise in the future. Although seclusion in any form is inherently degrading and will impinge on s 9 of NZBORA to an extent, reform can result in a more rights-consistent form of seclusion. The

[166] Ministry of Health, above n 63, at 6.
[167] Ministry of Health, above n 63, at 4.
[168] Shalev, above n 120, at 60.
[169] Ministry of Health, above n 63, at 4.
[170] Shalev, above n 120, at 60.
[171] At 60.

ultimate goal is to eliminate seclusion in New Zealand. Nevertheless, whilst it is still being practiced, the standards of seclusion must be improved to be less restrictive for patients.

IX Conclusion

Despite the proven negative effects of seclusion, New Zealand continues to adopt the practice in DHBs across the country. The legislative framework does not provide adequate guidance on how seclusion should be administered, resulting in many patients being deprived of the most basic provisions. Ashley Peacock remained in seclusion for eight years, despite his parents, the Ombudsman and the public exhausting all avenues to advocate for his removal. This case not only highlights the barriers to reducing seclusion for health authorities but also the negative impacts it can have on the treatment of the patient.

Through applying the *Moonen* test and carrying out a s 5 analysis, this paper established that seclusion breaches s 9 of NZBORA and cannot be justified in a free and democratic society per s 5. There are clear alternative practices that would constitute a lesser impingement on s 9, whilst still achieving Parliament's objective. The Government is aware of this and has implemented initiatives including the Six Core Strategies checklist and Zero Seclusion. However, despite these efforts, seclusion is still prevalent in some DHBs.

Legislative reform may offer a more sustainable solution to improving seclusion standards across the board. Incorporating minimum standards for seclusion rooms and minimum entitlements for secluded patients under s 71 will result in seclusion being more consistent with NZBORA. Changes to the guidelines can reinforce any changes to the legislation. Seclusion as it stands now, has no place in New Zealand and a case like Ashley Peacock's should never be allowed to arise again.

Word count

The text of this paper (excluding table of contents, footnotes, and bibliography) comprises approximately 7,840 words.

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