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ARTICLE

Protection for Patients in the Quiet Room: A Rights-based Review of New Zealand's Mental Health Law on Seclusion

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Seclusion is the lawfully justified practice of clinical intervention for the care, treatment or protection of mental health patients. This article critically reviews the inadequate protection for the rights of mental health patients subjected to seclusion in New Zealand. Recent findings show persistent failures in the legislative framework to reflect a modern approach to mental health. Instead, the framework preserves a practice recognised as degrading, punitive and inhumane. First, this article analyses the legal framework, the Mental Health (Compulsory Assessment and Treatment) Act 1992, which continues to justify the use of seclusion. In assessing the impact of seclusion on a patient's rights under the New Zealand Bill of Rights Act 1990 and Code of Health and Disability Services Consumers' Rights, this article identifies a need for stronger safeguards in the law to protect patients' rights and to restrictively regulate the practice of seclusion in clinical settings. To eliminate seclusion in New Zealand, the law governing the care and treatment of some of society's most vulnerable members must be robustly rights-based and restricted in the progress towards prohibition.

I Introduction

A mental health patient in seclusion is locked and alone in a room without the freedom to exit. From the lived experience perspective of this patient, they have been involuntarily placed in "what was euphemistically called a 'quiet room' or 'seclusion' which was empty

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except for a bare mattress on the floor" and left alone in this isolation at a time when they "most needed for some form of empathetic human contact".[1]

Released in August 2020, the Ombudsman Report on an unannounced inspection of the Waiatarau Mental Health Inpatient Unit at Waitakere Hospital unveiled disheartening findings regarding seclusion conditions. A seclusion room was described as "stark", without natural light due to "closed and not operational" window blinds, and with access only to a cardboard receptacle as a toilet.[2] After delayed publication, the 2018–2019 annual report of the Office of the Director of Mental Health and Addiction Services was released in March 2021. The data gathered between 2018 and 2019 showed an increase in seclusion events from 2,719 to 2,885. The number of secluded people increased from 854 to 931.[3] While the hours in seclusion have decreased by 55 per cent since 2009 (49 per cent including outliers), there has been a 10 per cent increase in seclusion hours and a seven per cent increase in seclusion events between 2017 to 2018 (25 per cent and 26 per cent respectively including outliers).[4] The recent increased use and duration of seclusion in New Zealand mental health services highlight a pressing need for change.

The practice of "seclusion" is permitted under s 71(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). In the absence of a statutory definition, the Human Rights Commission defines seclusion as "any practice that involves confinement, isolation or reduction in sensory input", usually by being locked alone and controlled in their movement in and out of this state.[5] Patients' perspectives of seclusion are overwhelmingly negative. They describe seclusion as a re-traumatising and dehumanising experience that undermines the goals of recovery.[6] Despite this, the MHA justifies the use of seclusion "for the *care and treatment* of the patient, or the *protection* of other patients".[7]

The seclusion of mental health patients engages core human rights concerns for New Zealand. Seclusion involves depriving a person of their liberty, and the quality of this deprivation can be degrading. Section 23(5) of the New Zealand Bill of Rights Act 1990 (NZBORA) provides for the rights of persons deprived of liberty to be treated with humanity and respect for their inherent dignity. This right protects patients compulsorily admitted and subjected to seclusion under the MHA, and complements the protections against degrading treatment or punishment contained in s 9 of the NZBORA. Although s 5 of the NZBORA implies that rights and freedoms are not absolute, this article shows that not all rights guaranteed in the NZBORA should be open to reasonably justified limitations.

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1 David W Oaks "Whose Voices Should Be Heard? The Role of Mental Health Consumers, Psychiatric Survivors, and Families" in Michael Dudley, Derrick Silove and Fran Gale (eds) *Mental Health and Human Rights: Vision, Praxis, and Courage* (Oxford University Press, Oxford, 2012) 566 at 566.

2 Peter Boshier *OPCAT Report of an unannounced inspection of Waiatarau Mental Health Inpatient Unit, Waitakere Hospital, under the Crimes of Torture Act 1989* (Office of the Ombudsman, August 2020) at 13.

3 Ministry of Health *Office of the Director of Mental Health and Addiction Services Annual Report 2018 and 2019* (30 March 2021) at 84–85.

4 At 84.

5 Human Rights Commission *Report on Human Rights and Seclusion in Mental Health Services* (June 2008) at 6.

6 Lisa M Brophy and others "Consumers' and their supporters' perspectives on barriers and strategies to reducing seclusion and restraint in mental health settings" (2016) 40 Aust Health Rev 599 at 602.

7 Mental Health (Compulsory Assessment and Treatment) Act 1992 [MHA], s 71(2)(a) (emphasis added).

The United Nations (UN) has criticised New Zealand's continued use of seclusion in psychiatric facilities. In 2014, the UN recommended eliminating seclusion practices in New Zealand's psychiatric institutions.[8] Seclusion was identified as being inconsistent with the rights to liberty and security protected by art 14 of the Convention on the Rights of Persons with Disabilities (UNCRPD).[9] In 2015, the UN expressed further concerns that seclusion was being practised excessively in New Zealand's mental health facilities as punishment and for disciplinary purposes.[10] New Zealand ratified both the UNCRPD and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT)[11] in 2008 and 1989 respectively, thus committing to the implementation of rights and obligations contained in the Conventions.[12]

Following observations by the UN, the government has focused on reducing seclusion practices in New Zealand's mental health facilities. Most notably, "Pathways to Eliminate Seclusion by 2020" was a policy initiative implemented jointly by Te Pou and the Health Quality and Safety Commission (HQSC) since 2018.[13] After failure to eliminate seclusion by 2020, the HQSC has renamed the project as "Zero seclusion: safety and dignity for all | Aukatia te noho punanga: noho haumanu, tū rangatira mō te tokomaha" and aims to achieve a 50 per cent reduction in seclusion events by 1 June 2022, but no longer provides a target date for eliminating seclusion.[14]

While mental health service providers are committed to reducing seclusion, there has been no rights-based review of the legal framework that continues to legitimise the use of seclusion on the grounds of necessity. Efforts to transform the MHA by repeal and replacement, thereby addressing the concerns surrounding the use of seclusion in the process, are ongoing and uncertain.[15] Under the MHA Guidelines, which the Ministry of Health republished in September 2020, seclusion is still permitted as a last resort and in "rare cases" for the safety of the patient and others.[16] Legislative resistance to the prohibition of seclusion emphasises the need for stronger legal protections for mental health patients who are vulnerable to being placed in seclusion.

This article discusses whether the law provides adequate protection for the rights of mental health patients subjected to seclusion. While intended to operate as safeguards for patients placed in seclusion, justifications recognised in law should reflect modern approaches to mental health care and treatment. Of serious concern is the over-reliance

8 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.

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

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

11 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1465 UNTS 85 (opened for signature 10 December 1984, entered into force 26 June 1987) [UNCAT].

12 Ministry of Justice "International Human Rights Legislation" <www.justice.govt.nz>.

13 Health Quality & Safety Commission New Zealand "New projects seek to eliminate seclusion and improve service transitions for mental health consumers" (4 January 2018) <www.hqsc.govt.nz>.

14 Health Quality & Safety Commission New Zealand "Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha, Zero seclusion: Safety and dignity for all" (12 October 2021) <www.hqsc.govt.nz>.

15 Ministry of Health *Transforming our Mental Health Law: A public discussion document* (October 2021) at 46.

16 Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (September 2020) at 103.

on professional discretion to protect patient rights. The lack of clear regulatory guidelines for practitioners enables the continuing inhumane and degrading practices of seclusion in New Zealand's mental health care. By assessing legislation and judicial approaches from a human rights perspective, this article supports growing concerns that New Zealand's current legal framework for seclusion is inadequate to protect the rights of mental health patients. Furthermore, this article considers the scope for law and policy reform in the progress towards eliminating seclusion from New Zealand's mental health care. The quality of patients' seclusion experiences must be improved to a humane standard through rights-based and person-centred practices of seclusion. The law should reflect society's responsibility to treat all its members, including its most vulnerable, humanely and with dignity.

II Legislative Framework

The law on seclusion in New Zealand is found in mental health legislation. The primary legislation which governs the use of seclusion is the MHA. The purpose of the MHA is to define and protect the rights of persons subject to compulsory treatment for mental disorders as a result of unwillingness or inability to consent to voluntary treatment.[17]

A *Mental Health (Compulsory Assessment and Treatment) Act 1994*

"Seclusion" is a form of clinical management permitted under the conditions provided for in the MHA.[18] Use of seclusion is restricted to the purposes of "necessary … care or treatment of the patient, or for the protection of other patients".[19] Section 71(2)(a) is an express exception to the right to the company of others in s 71(1). These conditions, which justify the use of seclusion, are consistent with the scope of the MHA. The MHA applies only to persons who are mentally disordered as defined in s 2 or are subject to a compulsory treatment order.[20] Necessary components to satisfy the definition of "mental disorder" in s 2(1)(a) include "an abnormal state of mind" that presents a "serious danger" to the health and safety of the person or others. The consistency between s 71(2) justifications and the s 2 definition implies that risk to self or others is a necessary condition to be compulsorily placed in seclusion under the MHA.

To supplement s 71 and limit the use of seclusion in mental health acute inpatient units, the Ministry of Health Seclusion Guidelines and the Health and Disability Services Standards provide guidelines around best practice standards and methods for seclusion.[21] In particular, seclusion is deemed appropriate for the control or prevention of harmful, destructive or disturbed behaviours emerging from a psychiatric illness—and only when psychological techniques are inadequate.[22] These guidelines embody industry practices

17 MHA, preamble.
18 Section 71.
19 Section 71(2)(a).
20 *Re B [seclusion]* (1993) 11 FRNZ 174 (FC) at 178.
21 Ministry of Health *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (February 2010) at iii; and Technical Committee P8134 *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (Standards New Zealand, NZS 8134.2:2008, 8 October 2008), which will be superseded on 28 February 2022: see P8134 Health and Disability Services Standard Committee *Ngā Paerewa Health and Disability Services Standard* (Standards New Zealand, NZS 8134:2021, 30 June 2021).
22 Ministry of Health, above n 21, at 5.

and standards for seclusion. The mental health profession and its service recipients acknowledge seclusion as an evidence-based intervention to prevent self-harm and ensure the safety of all persons.[23] In practice, the most common explanation for the use of seclusion in mental health units is the risk of harm to others, followed by the risk of harm to self.[24] These guidelines identify risk factors and safeguards to be considered before, during and after seclusion. The importance of these restrictive considerations show a recognition of seclusion as a cautious practice. Human rights concerns regarding inhumane or degrading treatment and punishment are central to the need for caution in using seclusion. Under this view, justifications for seclusion both *authorise* the use of seclusion under permissible conditions and *restrict* the use of seclusion to those conditions alone. The restrictive function is intended to protect the rights of patients placed in seclusion.

There are two underlying justifications for the use of seclusion: to protect against potential harm to self and to protect against potential harm to others. Each justification is embodied in the MHA, and acknowledged in case law and policies (discussed below) which regulate the clinical practice of seclusion. What follows is a discussion of the strength of these justifications in restricting the use of seclusion and how such restrictions on seclusion may provide protections for the rights of patients.

(1) Protection of the patient

The first justification for seclusion is to protect the patient. Section 71(2)(a) of the MHA justifies the use of seclusion for the necessary "care or treatment" of the patient. The interests of individual patients are central to this justification. Care or treatment of the patient essentially involves practices to protect the patient from self-harm or from situations where the patient may be harmed.

The Seclusion Guidelines emphasise extreme caution in the use of seclusion where the patient shows a likelihood of self-injuring behaviour or further deterioration as a result of seclusion.[25] In these situations, seclusion may exacerbate the patient's mental health condition, contrary to the care or treatment purposes of seclusion. Whilst the MHA provides broad discretion for clinicians to use seclusion for protective purposes, regulations also limit the use of seclusion if harm to the patient from being placed in seclusion outweighs the harm from not being placed in seclusion. Harm in these situations includes the "potential physical and psychological effect[s]" on the patient, which are critical considerations when commencing seclusion.[26] This proportionality of harm approach strengthens the justification for seclusion because it ensures that the use of seclusion is not arbitrary and that there are patient-centred safeguards to prevent violation of patient rights.

However, to permit the use of seclusion for "care or treatment" of the patient would be to recognise and encourage the use of seclusion as a therapeutic practice. This endorsement of seclusion is inconsistent with patient experiences, highlighting the inhumane and degrading nature of seclusion. In the 1993 case of *Re B [seclusion]*,

23 Aricca D Van Citters, Umadevi Naidoo and Mary Ellen Foti "Using a Hypothetical Scenario to Inform Psychiatric Advance Directives" (2007) 58 Psychiatr Serv 1467 at 1468.

24 Mosunmola Tunde-Ayinmode and John Little "Use of seclusion in a psychiatric acute inpatient unit" (2004) 12 Australas Psychiatry 347 at 350.

25 Ministry of Health, above n 21, at 5.

26 At 1.

the Family Court regarded seclusion as a "beneficial therapy",[27] and reflective of the standard care and treatment of patients with serious intellectual disabilities.[28] This view of seclusion as a therapeutic practice is no longer supported today.

Earlier research promoting the therapeutic value of seclusion are outdated and inappropriate in light of the growing evidence to the contrary.[29] Research today demonstrates that restrictive practices such as seclusion have negative impacts on psychiatric inpatients.[30] A meta-analysis of qualitative data on the lived experiences of seclusion identified negative consequences on emotions (such as feelings of loneliness, fear and powerlessness); cognition and behaviour (hallucinations); and perceptions of punishment, dehumanisation and sensory deprivation.[31] Thus, not only does use of the term "treatment" in regard to seclusion fail to reflect modern approaches to mental health, but it also provides legal preservation of a degrading and inhumane practice. The law should not encourage the use of seclusion in this way or hold it out as a favourable practice. Rejection of seclusion as treatment in legislation would aid the movement towards eliminating seclusion practices while also creating greater protection for the rights of mental health patients to be free from inhuman and degrading treatment.

(2) Protection of others

While the first justification focuses on the interests of the patient, the second justification looks to the interests of others. Under s 71(2)(a) of the MHA, "protection of other patients" is expressly identified as a circumstance justifying the use of seclusion. All patients admitted under the MHA are entitled to the protections provided by the MHA, including protection against the risk of harm presented by other patients. This justification represents an obligation on mental health practitioners to ensure the health and safety of all patients. Health and safety obligations are enforced by the Ministry of Health and monitored by the HQSC.[32] The priority to protect all patients in mental health facilities from risk of harm—including self-harm or harm from another patient—is consistent with the law's objectives to protect the health and wellbeing of all New Zealanders.[33] There is nothing to suggest that mental health practitioners should not also be protected. However, the parameters of the s 71(2)(a) justification are limited to the interests of "other patients". This wording suggests that the MHA excludes the use of seclusion for staff protection.

The courts have broadened the justifying conditions in s 71(2)(a) of MHA to permit the use of seclusion to protect all persons, including other patients and staff, who may be at risk of harm from the patient's behaviour. In *Re B [seclusion]* and *J v Crown Health Financing Agency*, the courts recognised the use of seclusion to ensure the safety and welfare of other patients and staff.[34] In both cases, the patient's periodic outbursts of

27 *Re B [seclusion]*, above n 20, at 176.

28 At 182.

29 Thomas G Gutheil "Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient" (1978) 135 Am J Psychiatry 325.

30 William A Fisher "Restraint and Seclusion: A Review of the Literature" (1994) 151 Am J Psychiatry 1584 at 1587–1588.

31 Amy Mellow, Anna Tickle and Michael Rennoldson "Qualitative systematic literature review: the experience of being in seclusion for adults with mental health difficulties" (2017) 22 Mental Health Review Journal 1.

32 New Zealand Public Health and Disability Act 2000, s 59A–59C.

33 Section 3(1)(a)(i).

34 *Re B [seclusion]*, above n 20, at 179; and *J v Crown Health Financing Agency* HC Wellington CIV-2000-485-876, 8 February 2008 at [620].

violent behaviour that had harmed (or had the potential to harm) others necessitated the use of seclusion. From a legal perspective, seclusion is justified for the purpose of protecting other persons affected by the patient's condition. Whilst the MHA could be improved to reflect this judicial approach, s 71(2)(a) sufficiently limits the purposes for which seclusion may be permitted. By limiting the use of seclusion to protective purposes, patients are further guarded against abusive practices of seclusion intended to degrade and punish.

The MHA uses the concepts of necessity and imminence to guide the use of seclusion for protective purposes. Seclusion as care or treatment is permitted if "necessary" under s 71(2)(a) or in a situation of "emergency" under s 71(2)(d). "Necessary" and "emergency" characterises circumstances of necessity and imminence. In *Re O*, the meaning of "serious danger" was considered to have stronger implications than mere danger, and required a degree of imminence and demonstrability of harm.[35] Just as the adjective "serious" qualifies the ordinary meaning of "danger", the word "necessary" is a qualifying adjective of "care or treatment" and "protection of other[s]" in s 71(1)(a). If the purpose of seclusion is to protect the patient and others from harm, "harm" should be qualified by a degree of imminence and demonstrability to the extent that seclusion is the only available course of action to achieve that protection. The consideration of qualifying factors, such as imminence and demonstrability of harm, by mental health practitioners provides additional safeguards against the arbitrary use of seclusion.

However, legal safeguards are limited as there is no requirement or criterion of imminence in the empowering provisions of the MHA or the Seclusion Guidelines. Instead, the MHA relies entirely on the exercise of clinical discretion and judgement as to which circumstances necessitate the use of seclusion. Whether seclusion will prevent self-harm or harm to others is also a matter of clinical judgment. The current MHA reflects the conventional principle of judicial non-interference in areas of clinical judgment by authorising the use of seclusion in this way.[36] However, clarifying that s 71(2) of the MHA requires imminency and demonstrable harm as preconditions of necessity would help prevent arbitrary and abusive practices that breach the rights of mental health patients.

III Rights of Mental Health Patients

New Zealand legislation and international covenants provide protections for the rights of mental health patients. The NZBORA affirms and guarantees fundamental rights and freedoms, subject to justified limitations in s 5. Mental health legislation, including the MHA and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (the Code), provide for the rights of patients undergoing care and treatment. The rights protected under New Zealand law accord with ratified international human rights instruments—in particular, the UNCRPD and the UNCAT. What follows is an analysis of New Zealand's legal protections for patients' rights in the context of seclusion and in light of the requirement under s 6 of the NZBORA to interpret enactments in a manner consistent with the NZBORA.

35 *Re O* [1993] NZFLR 545 (DC) at 546.

36 See *R v Portsmouth Hospitals NHS Trust (ex parte Glass)* [1999] 2 FLR 905 (CA) at 910–911.

A *The NZBORA: ss 9, 22 and 23(5)*

Mental health patients are entitled to the fundamental rights protected by the NZBORA. Most relevant to seclusion are the right not to be subjected to "cruel, degrading, or disproportionately severe treatment or punishment" under s 9, the right not to be arbitrarily detained under s 22, and the right of persons deprived of liberty to be "treated with humanity and with respect for the inherent dignity of the person" under s 23(5). Sections 9, 22 and 23(5) trigger several human rights concerns. These concerns relate to the placement of patients in seclusion in breach of the s 22 right to liberty and in seclusion conditions that breach the s 23(5) right to be treated with humanity and dignity.

(1) Right to liberty

The right to liberty and freedom from arbitrary detention is protected in s 22 of the NZBORA and further affirmed in art 14 of the UNCRPD. This right seeks to ensure that any constraint or harm associated with detention is justified in accordance with the law.[37] First, for seclusion to amount to a "deprivation of liberty" that reaches the threshold for detention rather than mere restriction, the circumstances of the seclusion (including its length, effects and manner of confinement) must constitute social isolation.[38] Secondly, whether the detention is arbitrary depends on the degree to which the detention is unreasonable or disproportionate beyond simply the legality of detention.[39] The possibility of indefinite or prolonged seclusion under the MHA, which imposes no restriction on the maximum duration of seclusion, indicates a lack of legal safeguards against arbitrary detention of patients.

(2) Right to humane treatment

The ambit of s 23(5) is defined in the leading authority of *Taunoa v Attorney-General*.[40] While this case is concerned with the rights of detained prisoners, the Supreme Court's approach assists in assessing the rights of secluded patients under the MHA.[41] The majority in *Taunoa* distinguished between inhuman treatment prohibited under s 9 and inhumane treatment prohibited under s 23(5).[42] Blanchard J summarises this distinction by describing s 23(5) as protecting against "conduct which lacks humanity, but falls short of being cruel; which demeans the person, but not to an extent which is degrading; or which is excessive in the circumstances, but not grossly so".[43] On a continuum of seriousness, the more egregious conduct that is grossly cruel and degrading is the inhuman and dehumanising treatment prohibited by s 9. Therefore, s 23(5) contemplates a lower threshold for a breach than s 9. The legal distinction between ss 9 and 23(5) contemplates the possibility that where there is a breach of s 23(5) but not of s 9, a patient may nonetheless be treated as human despite being treated inhumanely and

37 Andrew Butler and Petra Butler *New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at 1088.

38 *Secretary of State for the Home Department v JJ* [2007] UKHL 45, [2008] AC 385 at [15]–[16].

39 *Zaoui v Attorney-General* [2005] 1 NZLR 577 (CA) at [100] and [175].

40 *Taunoa v Attorney-General* [2007] NZSC 70, [2008] 1 NZLR 429.

41 See *B v Waitemata District Health Board* [2017] NZSC 88, [2017] 1 NZLR 823 at [56], which considered *Taunoa*, above n 40, in the context of mental health facilities.

42 *Taunoa*, above n 40, at [170]–[171] per Blanchard J.

43 At [177].

without humanity. Section 23(5) therefore represents the minimum standard for seclusion conditions deemed sufficiently humane to protect a patient's rights under the NZBORA.

Elias CJ's dissent in *Taunoa* provides further guidance on assessing conditions of suffering in light of the different thresholds required by ss 9 and 23(5).[44] While inhumane treatment under s 23(5) is not equivalent to inhuman treatment under s 9, to consciously treat a person inhumanely in breach of s 23(5) would be to dehumanise that person in breach of s 9.[45] It follows that without any intention to inflict suffering, the use of seclusion may be inhumane treatment but would be reasonably justified under s 5 of the NZBORA. However, intention is to be assessed objectively: conditions of deprivation which are systematically imposed to modify behaviour indicate a conscious use of inhumane treatment which would amount to a breach of s 9.[46] Hence, protection of a patient's rights under ss 9 and 23(5) of the NZBORA relies on the assurance that conditions of seclusion are clinically necessary and appropriate.

(3) Limitation of rights under s 5

Section 5 of the NZBORA recognises that rights are not absolute and must be subject to reasonable limits that are "justified in a free and democratic society". The application of s 5 involves considerations of reasonableness and proportionality as separate but related questions to understanding the specific rights in the NZBORA.[47] Sections 9 and 22 contain "internal modifiers" which "qualif[y] the scope" of activity that requires justification.[48] For instance, breach of rights under s 9 depends on the proportionality of severe treatment or punishment, and breach of s 22 depends on the arbitrariness of detention.[49] In adopting the views of a free and democratic society, as s 5 of the NZBORA suggests, it is difficult to conceptualise a world in which the right to be treated with dignity and as a human being can be subject to "reasonable limits". Nevertheless, s 5 of the NZBORA permits certain limitations on rights to the extent that these limitations are reasonable and proportionate. As this article argues, while there may be disagreement on what constitutes cruel, degrading or disproportionately severe treatment, treatment that degrades a person's human dignity should never be justified as reasonable.

B *Interpretation consistent with the NZBORA*

Section 6 requires enactments to be interpreted in a manner consistent with the rights expressed in ss 9 and 23(5) of the NZBORA. The affected rights in relation to seclusion are contained primarily in the MHA and enforced through the regulatory framework that governs the clinical practice of seclusion.

(1) Section 71 of the MHA

The MHA provides special protections for the rights of patients subject to compulsory treatment. Section 71(1) provides for the right to the company of others. Since the persons

44 At [91] and [69] per Elias CJ dissenting. It was found that there was a breach of both ss 9 and 23(5). Compare this with the majority at [297], who held there was only a breach of s 23(5).
45 At [7] and [69].
46 At [69] per Elias CJ dissenting.
47 Andrew S Butler "Limiting Rights" (2002) 33 VUWLR 537 at 541–542.
48 At 544.
49 At 544.

that may comprise "others" are not circumscribed in the MHA, s 71(1) is likely to be broadly inclusive of contact with family, other patients and the wider community. Social inclusion of this kind is accepted as being fundamental to the rights of mental health service recipients to be treated as equal members of New Zealand society.[50] The rights contained in s 71(1) reflect elements of art 19 of the Convention on the UNCRPD. Article 19 of UNCRPD provides for the equal right of persons with psychosocial disabilities to "live in the community, with choices equal to others".[51] Having ratified the UNCRPD, New Zealand's commitment to facilitating the appropriate social inclusion and participation of mental health patients is reflected in s 71(1) of the MHA.

Under the MHA, social inclusion and seclusion are both forms of "care". Seclusion for the purposes specified in s 71(2) justifies the limitations on the right to the company of others. While care in the form of social inclusion is a right, care in the form of seclusion is a legally permitted limitation on this right. This distinction is essentially based on the differing objectives of ss 71(1) and 71(2). The right to company and social inclusion aims to improve the patient's mental health, whereas the justified use of seclusion aims to protect against self-harm or harm to others. Viewed together, these objectives suggest that s 71 protects a mental health patient's right to the company of others only to the extent that engaging with others does not create a risk of self-harm or harm to others.

(2) Rights 3 and 4 of the Code

The Health and Disability Commissioners Act 1994 (HDCA) is another source of rights for mental health patients who are subjected to seclusion. The HDCA creates protection for rights outlined in the Code. The Code establishes rights for mental health patients and obligations for service providers. The rights under the Code largely reflect the rights contained in the NZBORA, and complement the rights in the MHA. These rights include the right to be treated with respect and dignity and the right to services of an appropriate standard.[52] These rights are specially protected for the "health consumer" who is any person receiving health care and services.[53]

While construed as a set of positive rights, the Code also affirms the corresponding duties of service providers to exercise clinical procedures (such as seclusion) with reasonable care and skill, in compliance with legal and professional standards, and in a manner that is respectful of the patient's dignity.[54] There is significant emphasis on reasonableness relating to issues of rights breaches or non-compliance. Rights under the Code are protected insofar as the provider can prove that reasonable actions were taken in the circumstances to give effect to the patient's rights.[55] Unlike the MHA, section 71 of which identifies the circumstances in which seclusion would be reasonably permitted, the Code is less specific. The Code should be interpreted as supplementing an understanding of s 71 of the MHA. For instance, right 4(4) of the Code recognises the right to care that minimises the potential harm to the patient and optimises the patient's quality

50 HP Hamer and others *Stories of Success: Mental health service users' experiences of social inclusion in Aotearoa New Zealand* (Mental Health Foundation of New Zealand, 2014) at 8.

51 UNCRPD, above n 9, art 19.

52 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 [Code], sch cl 2 rights 3–4.

53 Health and Disability Commissioners Act 1994, s 2.

54 Code, sch cl 2 rights 4(1)–4(2).

55 Schedule cl 3(1).

of life. The duty of mental health service providers to minimise harm is also inherent in s 71(2)(a) of the MHA, which justifies the use of seclusion to protect patients from harm.

(3) Section 6 analysis

Section 6 of the NZBORA gives preference to rights-based interpretations of legislation. In accordance with the rights under ss 9 and 23(5) of the NZBORA to be treated as human and with humanity, the right to social inclusion in s 71(1) of the MHA derives its fundamental quality from a sense of belonging, which is a basic human need.[56] This right is critical for patients subject to compulsory treatment, who are already isolated from society in inpatient units. The use of seclusion for mental health patients to protect the patient or others from harm must be justified in the first-stage inquiry as to the scope of the patient's right under s 71(1) of the MHA.[57] As a separate second-stage inquiry, when considering the reasonableness of the limitations on rights, the limitations must be clearly justified as the least intrusive and only effective means to achieve its intended purpose.[58]

Currently, enforcement of humane conditions of seclusion is achieved by imposing obligations on mental health practitioners who are empowered to use seclusion under the MHA. In all circumstances of compulsory treatment, such as seclusion, a rights-based "least restrictive" approach consistent with the NZBORA and the Code must be achieved to the extent it is possible. These legislative protections are also recognised in the Code of Ethics which prioritises respect for "humanity, dignity and autonomy of all patients" as the first ethical principle.[59] However, the discretionary nature in which the powers under s 71 of the MHA may be exercised to seclude patients highlights a deficiency in how the law operates in practice.

To more robustly protect the rights of mental health patients, there needs to be a clear legal requirement for mental health practitioner to exercise their s 71 powers in a manner consistent with the NZBORA. There is an expectation imposed on the legislature to adopt the most ambitious means, rather than the bare minimum, to protect the rights of vulnerable people.[60] The most ambitious means would be to prohibit the use of seclusion in mental health units. A moderated alternative would be to ensure stricter guarantees of humane conditions of seclusion in the MHA to protect the fundamental rights of mental health patients to be treated as human and with humanity.

When applying a rights-based and patient-centred approach to seclusion, the starting point for considering the use of seclusion should be whether seclusion is conducive to the patient's ongoing recovery. Although absent in the MHA, the protection of a patient's right to the company of others must be strengthened by a recovery approach prioritised by the mental health system. The recovery approach supports the individual's pursuit of full self-potential.[61] Part of realising the capacity for self-directed life is social reintegration. Mental health patients should, therefore, be supported in their inclusion and participation with

56 Roy F Baumeister and Mark R Leary "The Need to Belong: Desire for Interpersonal Attachments as a Fundamental Human Motivation" (1995) 117 Psychological Bulletin 497 at 499.

57 *R v Oakes* [1986] 1 SCR 103 at 138.

58 At 139.

59 The Royal Australian & New Zealand College of Psychiatrists *Code of Ethics* (2018) at 7.

60 *Irwin Toy v Quebec (Attorney-General)* [1989] 1 SCR 927 at 999.

61 Te Pou o te Whakaaro Nui and Ministry of Health *Let's get real: Real Skills for working with people and whānau with mental health and addiction needs* (October 2018) at 63.

others as a therapeutic goal in clinical practice.[62] Legal recognition of an aim to facilitate recovery of the patient in the MHA would further strengthen the rights contained within it.

IV Seclusion as Punishment

The case of *J v Crown Health Financing Agency* demonstrates the importance of mental health practitioners using seclusion as a protective measure rather than as a form of punishment.[63] In this case, the plaintiff was a compulsorily admitted mental health patient who was alleged placed in seclusion unlawfully.[64] The use and threat of seclusion by staff to control the patient's "misbehaviour" and create "obedience" was argued to be punishment.[65] Against the plaintiff's allegation, staff defended their actions as the "only possible" option to manage the destructive behaviours of patients towards themselves, other patients and staff.[66] The patient was diagnosed with schizophrenic symptoms, and violent and destructive behavioural tendencies, due to over-stimulus of sensory input.[67] In addressing whether seclusion of the patient constituted punishment, the High Court distinguished between the lawful use of seclusion which protects patients' rights, and the unlawful threat of seclusion which would violate the right of patients not to be subjected to inhuman punishment.

First, the Court held that where clinical practitioners regard the patient's behaviour as symptomatic of their mental health condition, the use of seclusion to protect an "unruly" patient from self-harm or to protect the safety of other patients or staff does not constitute punishment.[68] This approach is consistent with s 71 of MHA, which justifies the use of seclusion for the protection of the patient and others. While the Court did not reject the therapeutic value of seclusion at the time of the patient's experiences, the Court relied heavily on the protection purposes of seclusion to lawfully justify its use.

Secondly, the Court recognised seclusion as a potential form of punishment where there is evidence of punitive intent or purpose.[69] In arriving at this conclusion, the Court distinguished between a "threat" carrying the intent to punish and "statements" about the consequences of misbehaviour.[70] This distinction is determined from the subjective perspective of the practitioner. While, on the facts, the nurses had informed the patient that seclusion would be the likely consequence of behaving in a certain manner, the Court concluded that these statements were motivated by a desire to treat and protect the patient rather than to punish misbehaviour.[71] A judicial approach to seclusion based on a lack of punitive intent indicates negative protection for a patient's right not to be subjected to inhumane punishment. This approach is in contrast to the positive protection of rights provided by the requirement of protective intent to justify the use of seclusion under s 71 of the MHA.

62 Liz Sayce "Social inclusion and mental health" (2001) 25 Psychiatric Bulletin 121 at 121
63 *J v Crown Health Financing Agency*, above n 34.
64 At [64].
65 At [136] and [145].
66 At [235] and [299].
67 At [411] and [463].
68 At [470].
69 At [468].
70 At [472].
71 At [474].

A *Rights-based approach to seclusion*

The protection purposes of seclusion are central to s 71 of the MHA, which permits the use of seclusion. Section 9 of the NZBORA protects the rights of mental health patients against disproportionately severe punishment and is not open to reasonably justified limitations.

The current legal approach to seclusion focuses on the intention of clinicians in their decision to place the patient in seclusion, rather than the patient's experience of seclusion. Applying the principles in *Taunoa*, which assessed an alleged breach of s 9 of the NZBORA, the effects of seclusion on the patient is an important factor to be considered alongside the nature of seclusion and the state of mind of the responsible practitioner.[72] A nurse's affidavit in *J v Crown Health Financing* recognised that "it is certainly possible that the patients would have perceived their seclusion as punishment".[73] Thus, although seclusion may be a form of clinical intervention, the impact of seclusion on the patient suggests that seclusion is also capable of being used as a method of emergency containment or form of punishment.[74] Even with protective intent, the use of seclusion carries an inherent intention to control the patient with the knowledge that the patient is likely averse to the experience of seclusion. While this method of control may be permitted by law and outside the legal understanding of "threat", it is a form of intimidation that exploits the power dynamics between a mental health patient and a clinician. An unbalanced focus on the intentions of clinicians, which excludes considerations of the patient's experience, increases the potential for abusive seclusion practices.

The Seclusion Guidelines supplement the use of seclusion under s 71 of the MHA. These guidelines require the clinician responsible for the decision to consider the physical and psychological effects on the patient when commencing seclusion.[75] The effects of seclusion on the patient is a contributing factor for both the justifications for, and restrictions on, the use of seclusion. Where there is a risk of disproportionately adverse effects on the patient as a result of seclusion, seclusion would not be conducive to the "care or treatment" of the patient under s 71 of the MHA. Protection of a patient's right not to be punitively subjected to seclusion is therefore achieved through greater consideration of the perspectives of secluded mental health patients.

Although the Health and Disability Services Standards (NZS 8134.2.3:2008) expressly prohibit the use of seclusion for punitive reasons, the punitive risk of seclusion is no longer directly recognised in the updated 2021 Standards, which come into effect from 28 February 2022.[76] Moreover, there are no such protections guaranteed by the MHA. Therefore, changes are necessary to give explicit reference to punitive reasons and effects, thereby imposing a stricter standard of seclusion practice that is not experienced punitively by mental health patients.

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72 *Taunoa*, above n 40, at [291]–[295] per Tipping J and [353]–[369] per McGrath J.

73 *J v Crown Health Financing Agency,* above n 34, at [370].

74 T Mason "Seclusion Theory Reviewed — a benevolent or malevolent intervention?" (1993) 33 Med Sci Law 95 at 100.

75 Ministry of Health, above n 21, at 1.

76 Technical Committee P8134 *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (Standards New Zealand, NZS 8134.2:2008, 8 October 2008) at 6; P8134 Health and Disability Services Standard Committee *Ngā Paerewa Health and Disability Services Standard* (Standards New Zealand, NZS 8134:2021, 30 June 2021).

V Seclusion as Degrading Treatment

While there is a risk of degrading treatment or punishment in the use of seclusion, there are legal and practical safeguards to protect the rights of mental health patients. The legal rights-based approach to seclusion in New Zealand is focused primarily on whether the seclusion is justified by the circumstances permitted under s 71 of the MHA. The United Kingdom adopts an approach to justifying seclusion and protecting the rights of mental health patients that focuses on the obligations of mental health professionals.

A *The approach in* Munjaz

The approach in *Regina (Munjaz) v Mersey Care NHS Trust*, affirmed in the European Court of Human Rights in 2012, concludes that protection of rights is achieved by imposing obligations on mental health professionals to avoid conduct that would constitute "inhuman or degrading treatment" which is prohibited under art 3 of the European Convention on Human Rights.[77] In *Munjaz*, the plaintiff challenged the lawfulness of seclusion used for psychiatric inpatients on the grounds that departure from the Mental Health Act Code of Practice in England and Wales breached the patient's right not to be subjected to inhuman and degrading treatment.[78] The House of Lords found that the use of seclusion was lawful, and mental health practitioners might depart from professional guidelines if the departure is justified by good clinical and medical practice.[79] *Munjaz* has significant ramifications for the rights of mental health patients placed in seclusion.

The Court of Appeal in England and Wales recognised that the risk of breaching a patient's rights is inevitable in the use of seclusion.[80] Despite the severe vulnerability of secluded patients, the law does not go so far as to prohibit the use of seclusion due to there being no acceptable clinical alternatives. Instead, the approach in *Munjaz* imposes positive and negative obligations on mental health professionals to protect the rights of mental health patients. Positive obligations to provide care or treatment that effectively protect vulnerable patients include an obligation to prevent ill-treatment. The obligation to prevent ill-treatment may be positive in requiring reasonable steps to be taken, or negative in requiring the mental health professional to avoid conduct that would breach the patient's right not to be subjected to inhuman or degrading treatment.[81]

The approach in *Munjaz* separates the goals of protecting the patient's rights, and protecting against self-harm or harm to others. While safeguards in the seclusion policy are intended to protect the patient's right not to be subjected to inhuman and degrading treatment, the use of seclusion is intended to protect against harm to the patient or others. In this way, the law provides a framework of rights protection that acknowledges the importance of practical processes surrounding seclusion to help protect the rights of patients. The question of inhuman and degrading treatment thus depends on the adequacy and appropriateness of safeguards in the seclusion policy to prevent a real risk of ill-treatment. These obligations are fulfilled through safeguards such as the requirement for regular progress reports, review of the decision to seclude, safe observations and accessible mechanisms for the patient to seek judicial review. These

77 *Regina (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [2006] 2 AC 148; and *Munjaz v United Kingdom* ECHR 2913/06, 17 July 2012.

78 *Regina (Munjaz) v Mersey Care NHS Trust*, above n 77, at [1] and [7].

79 At [97].

80 *Regina (Munjaz) v Mersey Care NHS Trust* [2003] EWCA Civ 1036, [2004] QB 395 at [56].

81 *Regina (Munjaz) v Mersey Care NHS Trust*, above n 77, at [78].

measures are considered adequate and sufficient in preventing any real risk of ill-treatment or breach of rights.[82]

B *Departure from the Code of Practice*

Standards of medical and clinical practice have an important role in justifying the use of seclusion. The majority in *Munjaz* accepted that the Code of Practice provides guidance only, and departure from the Code of Practice at the discretion of professionals may be lawfully justified by "cogent reasons".[83] The purpose of the Code of Practice in the United Kingdom is to provide comprehensive guidance for professionals to carry out their responsibilities under the Mental Health Act 1983 (UK).[84] In effect, the Code of Practice safeguards the rights of patients by placing restrictions on the permissibility of seclusion.[85] Arguably, a departure from these rights-based practices can weaken the protection of rights offered by the law. For policy reasons, the majority in *Munjaz* preferred a degree of flexibility over an excessively rigid mental health system in which the appropriateness of seclusion is measured against accepted and professional standards rather than legally enforceable regulations.[86]

The approach in *Munjaz* emphasises the importance of restrictive safeguards in practice to protect the patients' rights against inhuman and degrading treatment. Notwithstanding the possibility for safeguards to depart from the prescribed guidelines, the law imposes a high standard of reasoning on practitioners if seclusion is to be practiced in mental health settings. This high threshold for justifying the use of seclusion aims to protect the rights of mental health patients to be free from inhuman and degrading treatment.

C *Application of* Munjaz *in New Zealand*

The approach to seclusion and patient rights in *Munjaz* focuses on the obligations of mental health professionals to take reasonable actions to avoid or refrain from conduct that would breach the rights of patients protected by mental health legislation. Case law on seclusion in New Zealand is limited. Therefore, the approach in *Munjaz* helps to review New Zealand's legal position on compliance standards and the extent to which they protect the rights of mental health patients.

The protection of rights based on professionals' obligations is inherent in s 71 of the MHA, the Seclusion Guidelines and the Code. Under New Zealand law, seclusion is permitted only for the purposes of "necessary" care or treatment, and the Code affirms obligations on mental health professionals to provide services that are appropriate to the patient and of an appropriate standard.[87] *Taunoa* also affirmed a positive duty on detaining authorities to treat the affected person as human and with humanity, and that duty may be breached by a failure to meet statutory obligations, irrespective of intent.[88] A related question arising from the concept of positive duties is the standard at which the

82 At [29].
83 At [21].
84 Department of Health *Mental Health Act 1983: Code of Practice* (The Stationery Office, 2015) at 9.
85 At 300–308.
86 *Regina (Munjaz) v Mersey Care NHS Trust*, above n 77, at [99].
87 MHA, s 71; and Code, sch cl 2 right 4.
88 *Taunoa*, above n 40, at [28]–[31] and [78] per Elias CJ and [162]–[163] per Blanchard J.

duty is breached. The approach in *Munjaz* would suggest that practices of seclusion which fail to meet appropriate clinical and professional standards would constitute a breach of the patient's right not to be subjected to inhuman and degrading treatment.

(1) Case study of Mr D

Similar to the approach in *Munjaz*, obligations on health professionals operate as safeguards to prevent arbitrary and abusive practices of seclusion that breach a patient's right not to be subjected to inhuman or degrading treatment under s 9 of the NZBORA. In New Zealand, the existing Code provides for a patient's right to services of an appropriate standard.[89] The Code imposes a corresponding obligation on health professionals to provide services of an appropriate standard.

The application of the Code to protect the rights of patients by enforcing appropriate standards of clinical practice is illustrated in the case of Mr D.[90] This case is a complaints decision by the Health and Disability Commissioner, who is tasked with independently promoting and protecting the rights of mental health service consumers under the HDCA.[91] Despite Mr D's sensitivity to psychiatric medication, the nurse had sedated and placed him in seclusion for an extended period of time, resulting in Mr D's death. The Commissioner found that, by failing to provide services with reasonable care and skill, the nurse had breached Mr D's right to services of an appropriate standard under the Code.[92] The "appropriate standard" is informed by the expectation of a reasonable and competent clinician in the relevant circumstances.[93] Although the actual decision to place Mr D in seclusion was not at issue, the process of seclusion was found to violate Mr D's rights.[94] This case demonstrates how obligations on health professionals operate to protect the patient's rights. If the approach in *Munjaz* were to be applied, a breach of the standards that place safeguards on seclusion practices would constitute a breach of the patient's rights against inhuman and degrading treatment.

(2) The Ombudsman's findings

Safeguards contained in professional guidelines would facilitate fulfilment of the obligations to protect the rights of mental health patients. Recent findings by the Ombudsman indicate weaknesses in protections of the right not to be subjected to cruel, inhuman or degrading treatment.[95] The broad legislative framework which permits and justifies the use of seclusion fails to adequately restrict the use of seclusion in New Zealand's mental health facilities.

New Zealand ratified the UNCAT in 1989.[96] Article 16 recognises New Zealand's commitment to protecting the right not to be subjected to acts of cruel, inhuman or

89 Code, sch cl 2 right 4.
90 *A Report by the Health and Disability Commissioner* (Case 02HDC08692, 31 October 2002).
91 Health and Disability Commissioner Act 1994, ss 6, 8 and 14.
92 *A Report by the Health and Disability Commissioner*, above n 90, at 21.
93 At 21.
94 At 20.
95 Peter Boshier *OPCAT Report of an unannounced follow up inspection of Te Whare o Matairangi Mental Health Inpatient Unit, Wellington Hospital, under the Crimes of Torture Act 1989* (Office of the Ombudsman, August 2020) at 1 and 8; and Boshier, above n 2, at 10 and 22.
96 Office of the High Commissioner for Human Rights "Status of ratification" (last updated 18 June 2021) <www.ohchr.org>.

degrading treatment amounting to torture.[97] The Ombudsman, under the Crimes of Torture Act 1989, is responsible for reporting on whether the treatment and conditions in these places are compliant with the UNCAT. In August 2020, the Ombudsman reported on breaches of art 16 in Te Whare o Matairangi and Waiatarau Inpatient Units.[98] There were two separate findings of degrading treatment: first, the use of seclusion rooms to sleep patients who were not subject to an official period of seclusion; and secondly, constant observation of patients urinating or defecating while in seclusion.

The first finding of degrading treatment affirms the strict restrictions on the use of seclusion. Seclusion rooms are to be used strictly for the purpose of seclusion. This requirement reflects the safeguards in s 71 of the MHA, which permit seclusion only under the specified circumstances—either for the care or treatment of the patient, or the protection of others. This means that mental health professionals are not authorised under the MHA to seclude patients who are not observed to require seclusion. In New Zealand, stronger legal protection for rights may be found in the Health and Disability Services Standards. These Standards are enforced under the Health and Disability Services (Safety) Act 2001, and limit seclusion practices to being used for safety reasons and within designated seclusion rooms only.[99] The Standards, therefore, impose obligations on health professionals to restrict the use of seclusion, and effectively help to reduce or prevent rights breaches. Consequentially, if restrictive practices are enforced by law, mental health patients would be better safeguarded against potential breaches of the right not to be subjected to degrading treatment.

The Code of Practice discussed in *Munjaz* is the United Kingdom counterpart to New Zealand's Seclusion Guidelines, and provides specific guidance for seclusion practices. However, the status of the Seclusion Guidelines is less prominent in New Zealand law. In the United Kingdom, the Code of Practice is recognised under s 118 of the Mental Health Act (UK) as overriding guidance for mental health practitioners. Although not legally enforceable, procedures contained within the Code of Practice provide substantial safeguards for the rights of mental health patients. By contrast, the MHA does not recognise the existence of the Seclusion Guidelines. Although the Seclusion Guidelines comprehensively supplement the legal protections and justifications for seclusion in s 71 of the MHA, the enforceability of the Seclusion Guidelines is untested in New Zealand law.

The second finding of degrading treatment further highlights the importance of having humane seclusion conditions that are enforceable in mental health facilities. This finding related to the inadequacy of the facility itself in accommodating an environment for seclusion that respected the patient's human dignity. Without the necessary facilities to relieve themselves during seclusion, which averaged 12 hours in duration, patients were forced to either wait until the end of seclusion or use a cardboard receptacle.[100] Since secluded patients are constantly monitored, the lack of toilet facilities enabled observations of mental health patients urinating or defecating. The Ombudsman condemned such viewing, and the enabling circumstances, as amounting to degrading treatment.[101]

97 UNCAT, art 16.
98 Boshier, above n 2; and Boshier, above n 95.
99 Technical Committee P8134, above n 21, at [2.3.1]–[2.3.2]; and P8134 Health and Disability Services Standard Committee, above n 21, at [6.2.1].
100 Boshier, above n 2, at 13.
101 At 14.

The Ombudsman's findings of degrading treatment suggest inadequate protection of rights as a result of regulatory non-compliance rather than weaknesses in the law. However, mental health patients remain vulnerable to rights breaches in the absence of a meaningfully enforceable standard of practice. The approach in *Munjaz* highlights the importance of a codified standard of practice against which obligations and rights breaches can be assessed. The MHA permits and justifies the use of seclusion, but does not require seclusion to be implemented humanely. Considering that a rights-based interpretation of the MHA is preferred under s 6 of the NZBORA, requirements for non-degrading treatment would be implied in the use of seclusion authorised under s 71 of the MHA. This kind of protection of rights envisaged by the NZBORA suggests that the law embraces a rights-based approach to seclusion but lacks specificity and accountability measures.

The issue highlighted by the Ombudsman's findings is that there is a lack of mandatory or minimum standards of seclusion conditions that adequately protect the rights of mental health patients. Access to toilet facilities is only a "desirable" condition under the Seclusion Guidelines.[102] In light of the approach in *Munjaz*, if the Seclusion Guidelines are to be the professional standards that safeguard the rights of patients, the standards themselves must protect the rights of patients to the maximum possible extent. In this respect, the Ombudsman's findings illustrate the weaknesses in professional standards which undermine the legal protections provided by the NZBORA.

VI Possibilities for Reform

Progress towards eliminating seclusion should be supported by mental health laws that restrict and ultimately prohibit the practice of seclusion in mental health settings. Recognising that absolute prohibition of seclusion is challenging at present, possibilities for immediate reform should be concerned with how New Zealand's mental health law on seclusion can be improved to better protect the rights of patients. Prohibiting the use of seclusion in law would inevitably need to be supported by changes to mental health services and facilities.

More specific and restrictive laws to regulate seclusion should be implemented to strengthen the rights provided by the NZBORA and the HDCA. The current legislative framework in New Zealand identifies restrictive parameters within which seclusion may be justified under s 71 of the MHA. These parameters provide reasonable clarity on the prohibition of the use of seclusion *but for* the necessary care or treatment of the patient, or the protection of others. However, the law relies on standards of clinical practice to safeguard against abusive or arbitrary conduct that breaches the rights of mental health patients. In light of the Ombudsman's findings of degrading treatment due to inadequate conditions of seclusion, discretionary standards of practice are insufficient to protect the right of patients to not be subjected to inhuman or degrading treatment.[103] The law on seclusion should be supplemented by higher minimum standards of practice to ensure conditions of seclusion are as humane as possible. Moreover, like s 118 of the Mental Health Act in the United Kingdom, a code of seclusion practice ought to be recognised in the MHA to solidify the status of practical safeguards in New Zealand law. By strengthening the clinical and legal importance of these practical safeguards, the quality

102 Ministry of Health, above n 21, at 6.
103 Boshier, above n 95; and Boshier, above n 2.

of mental health law in New Zealand would be improved to better protect the rights of patients placed in seclusion.

A patient-centred recovery approach to mental health supports a rights-based approach to seclusion. A recovery approach to mental health would not recognise seclusion as conducive to the "treatment" of the patient in the sense of facilitating therapeutic recovery.[104] However, the MHA does not clarify whether or not seclusion is part of the patient's treatment. Moreover, the permitted use of seclusion for "care or treatment" under s 71(2) does not necessarily limit the use of seclusion to protective purposes. More precise and restrictive justifications for seclusion would better protect the rights of patients in a manner that is reflective of modern understandings of mental health. Thus, the law should restrict the use of seclusion for protective purposes and the prevention of imminent harm.

Finally, given that mental health is concerned with the patient's state of mind, care and treatment should be responsive to the effect of seclusion on the patient. Qualitative studies have found that most patients' experiences of seclusion were associated with negative emotions such as feelings of being punished.[105] The lack of consideration for the patient's perspective in *J v Crown Health Financing* highlights possible shortcomings in the judicial approach to protecting the rights of patients subjected to seclusion. In particular, where a lack of punitive intention would justify the use of seclusion, there are no positive protections for the patient's right not to be subjected to punishment.[106]

Caution is arguably necessary when considering the subjective perspectives of a mental health patient. In some cases, the patient may be affected by a distorted understanding of reality. However, an objective rights-based understanding of the impact that seclusion has on the patient should, as a necessary consideration, still give balanced consideration to the patient's subjective experience of seclusion. This approach is aligned with the person-centred principles that prioritise care, and clinical decision-making that understands and responds to people's needs and preferences.[107] The Code and the HDCA, whose central aims are to promote and protect the rights of health consumers, also support a person-centred approach to mental health.[108] Rather than relying on professionals to be well-intentioned, an approach that considers the patient's perspectives of seclusion as a mandatory requirement would enable patients to proactively claim their rights. Legal and judicial approaches that are patient-centred would therefore provide stronger rights protections.

VII Conclusion

Just as mental health patients are restricted in their movement and rights, seclusion is a practice restricted by New Zealand's mental health law. Despite recognition of the damaging and traumatising impacts of seclusion on mental health patients, the use of seclusion continues to be lawfully justified for protective purposes.[109] Recent findings that

104 Te Pou o te Whakaaro Nui and Ministry of Health, above n 61, at 63.

105 Betty Kehl Richardson "Psychiatric Inpatients' Perceptions Of the Seclusion-Room Experience" (1987) 36 Nurs Res 234.

106 *J v Crown Health Financing Agency*, above n 34, at [472]–[473].

107 Ministry of Health *New Zealand Health Strategy: Future Direction* (April 2016) at 16.

108 Health and Disability Commissioners Act, s 6.

109 Ministry of Health, above n 16, at 88.

seclusion conditions can amount to degrading treatment bring renewed attention to the mental health legislation's persistent inability to adequately protect the rights of patients.

In support of New Zealand's commitment to reducing and eliminating seclusion, this article reviews the law on seclusion and identifies weaknesses in the protection of the rights of mental health patients. In particular, the legislative framework governing the use of seclusion provides limited guidance on rights-based practices of seclusion. Instead, a rights-based approach to seclusion is inferred from judicial approaches, the NZBORA and the Seclusion Guidelines. To improve the legal protection of the rights of mental health patients, the law must provide for a restrictive regulatory framework that actively enforces rights-based practices of seclusion. More robust protection of patient rights in New Zealand's mental health law is necessary to make progress towards reducing and eliminating seclusion.