Human Rights Commission Report

Human Rights and Seclusion in Mental Health Services

Human Rights Commission
Te Kahui Tika Tangata

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Contents Page

Introduction		4
	The Purpose of this Paper	5
	What is Seclusion?	6
	The Mental Health Commission's Report	6
1.	**International Human Rights**	7
1.1	The International Treaty Framework	7
1.2	Other International Standards	11
1.3	International Accountability and Reporting Procedures	15
2.	**Examples of How Human Rights' Principles have impacted on Mental Health Practice in other Countries**	18
2.1	European Union	18
2.2	Australia: The Burdekin Report and a Rights Analysis of Mental Health Legislation	26
3.	**Relevant Jurisprudence**	27
3.1	United States	27
3.2	European Court of Human Rights	28
3.3	United Kingdom	29

4. Legislative Regime Governing the use of Seclusion in New Zealand 31

4.1 New Zealand Bill of Rights Act 1990 31

4.2 Mental Health (Compulsory Assessment and Treatment) Act 1992 33

4.3 Health and Disability Commissioner Act 1994 35

4.4 Human Rights Act 1993 37

5. Relationship between Seclusion and Human Rights Standards in New Zealand 39

6. Conclusion 43

Introduction

In 2004 the Mental Health Commission published a report on the use of seclusion in New Zealand.[1] Later that year the Human Rights Commission published *Human Rights in New Zealand Today (HRNZT). HRNZT* reflected the findings of a consultation that had taken place over the preceding year and which was designed to identify how New Zealanders felt their human rights were protected at present and where there was room for improvement. Among the issues identified by participants was the inappropriate use of seclusion and the need for more information on current practice in meeting human rights standards for the care and safety of mental health service users.[2]

HRNZT was used to develop an action plan, *Mana ki te Tangata: The New Zealand Action Plan for Human Rights*. Among the actions is a proposal that the Human Rights Commission and the Mental Health Commission collaborate on a project to clarify human rights issues

[1] *Seclusion in New Zealand Mental Health Services* Mental Health Commission (2004).
[2] *Human Rights in New Zealand Today: Nga Tika Tangata O Te Motu* (2004) p. 197.

relating to the use of seclusion. In August of 2007 the Mental Health Commission asked the Human Rights Commission to progress the issue as a matter of some urgency given its relevance to their work on compulsory interventions in mental health services.

The Purpose of this Paper

This paper looks at the implications of New Zealand's international commitments in greater depth, and applies a human rights analysis to the present legislative regime and practice relating to seclusion. Initiatives and relevant jurisprudence from other countries are also discussed in order to provide an indication of how human rights criteria are increasingly influencing what is considered to be acceptable clinical practice.[3] Prior to this, a brief definition of seclusion and a summary of the key passages relating to human rights in the Mental Health Commission's Report will be presented.

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[3] See, for example, World Health Organisation *The Role of International Human Rights in National Mental Health Legislation* Department of Mental Health and Substance Dependence, Geneva (2004) and the earlier background paper by E Rosenthal & C Sundram*, International Human Rights and Mental Health Legislation* (2003); S Bell & W Brookbanks *Mental Health Law in New Zealand* (Brookers, 2d ed. 2005) Chapter 11 "Seclusion and Restraint"; NAMI Task Force Report "Seclusion and Restraints" Policy Research Institute, May 2003; Davidson, McCallion & Potter *Connecting Mental Health and Human Rights* Northern Ireland Human Rights Commission (2003) and cases such as *R v Mersey Care National Health Service Trusty ex p Munjaz* [2005] UKHL 58 and *S v Airedale NHS Trust* [2002] EWHC 1780.

What is Seclusion?

Seclusion is any practice that involves confinement, isolation or reduction in sensory input. Typically it involves a person being locked alone in a room with nursing staff controlling all aspects of their movements. Seclusion should not be confused with solitude which is voluntary and which some service users find therapeutic.

The Mental Health Commission's Report

The introduction of the Mental Health Commission's report stresses - the importance of ensuring that the rights of people placed in seclusion are observed, the need for a thorough transparent monitoring system, and rigorous adherence to existing legal protection. The report also contains a section on human rights and duty of care issues. This section concludes that, although New Zealand's present legal framework does not breach human rights law, the way it is implemented does not sit easily with some of New Zealand's international commitments.

1. International Human Rights

1.2 The International Treaty Framework

The contemporary international human rights framework has its origins in the Universal Declaration of Human Rights adopted by the General Assembly in 1948. The principles in the Declaration were subsequently refined in a number of international treaties. When a country ratifies one of these treaties it accepts that it will be bound by the terms of the treaty and guarantees its delivery domestically. In ratifying a treaty, therefore, a country recognises the international law and accepts a legal obligation to respect, promote and fulfil the rights in that treaty.

The two major treaties, in the current context, are the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic Social and Cultural Rights (ICESCR).[4] Together with the Universal Declaration these two treaties make up the International Bill of Rights.[5]

[4] New Zealand ratified both treaties in 1972.
[5] "The International Bill of Rights comprises the most authoritative and comprehensive prescription of human rights obligations that governments undertake in joining the UN" Weissbrodt, Fitzpatrick

The ICCPR deals with rights such as the right to justice and what are loosely termed "physical integrity" rights such as the right to life, to freedom from torture and to be treated with humanity and dignity. While some rights such the right to freedom from torture are absolute, others can be limited provided the limitation meets certain criteria. In the case of the ICCPR, a set of principles known as the Siracusa Principles set out the standards that must be met when a right is restricted.[6] Each of the criteria must be satisfied and any restriction should be of limited duration and subject to review.[7]

The ICESCR deals with rights such as the right to work, the right to adequate housing and the right to the highest attainable standard of physical and mental health. Although neither refers specifically to the rights of people with mental illness, they emphasise that rights (such as the right not to be subjected to cruel and degrading treatment, the right to

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and Newman *International Human Rights: Law, Policy and Process* (3d Edition, 2001).

[6] Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights.

[7] The Siracusa Principles require that any restriction is provided for and carried out in accordance with the law, is in the interest of the legitimate objective of general interest, is strictly necessary in a democratic society to achieve the objective, in response to a public health need, proportional to the social aim, and there are no less intrusive and restrictive means of achieving it, and is not imposed arbitrarily.

be treated with humanity and dignity and the right to the highest attainable standard of physical and mental health) apply equally to all people without discrimination.

Two recent international initiatives that are relevant to the issue of seclusion are the International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities (the Convention on the Rights of Persons with Disabilities) which became part of international law in May this year and the Optional Protocol to the Convention against Torture (OPCAT) which entered into force in 2006. [8]

The Convention on the Rights of Persons with Disabilities does not replicate the rights in the major treaties but is designed to increase the visibility of disabled people, ensuring a more just and inclusive society in which disabled people enjoy the same rights as everyone else.[9] Although the Convention does not refer to involuntary

[8] The Convention on the Rights of Persons with Disabilities came into effect on 3/5/2008 following ratification by the required number of States.

[9] For an in-depth discussion on the relationship of disability and the UN instruments see G Quinn and T Degener *Human Rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability*: UN Geneva and New York (2002); A Byrnes "Disability rights and human rights: plunging into the 'mainstream'?" paper presented at International seminar on human rights and disability, Stockholm Sweden (2000) available at www.independentliving.org/docs2.

treatment, it refers to protecting the integrity of the person and reinforces that rights such as the right to liberty and security of the person and freedom from cruel, inhuman or degrading treatment or punishment apply equally to people with disabilities.[10]

The OPCAT establishes an international inspection system for places of detention (including mental health facilities). New Zealand ratified OPCAT following enactment of the Crimes of Torture Amendment Bill.[11]

There are also a number of treaties that deal with the interests of specific groups such as children, women or people in detention who are considered to be particularly vulnerable since they might otherwise be overlooked in the mainstream UN system.[12]

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[10] Articles 17, 14, 15.

[11] The Bill created a system of National Preventive Mechanisms for the purpose of carrying out regular inspections of detention facilities. The Human Rights Commission (as the Central Preventive Mechanism) has a coordinating role.

[12] International Convention on the Rights of the Child: UN Doc A/44/49 entered into force 2 Sept 1990 (UNCROC); Convention on the Elimination of Discrimination Against Women: UN Doc. A/44/49 entered into force 3 Sept. 1981 (CEDAW); Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment: UN Doc. A/39/51 entered into force 26 June 1987.

1.2 Other International Standards

In addition to the treaties there are a large number of United Nations resolutions and declarations. Although these sources are not binding in the same way as international treaties they establish standards of behaviour and practice. Relevant resolutions and declarations are listed below.

1.2.1 Declaration on the Rights of Mentally Retarded Persons[13]

The Declaration on the Rights of Mentally Retarded Persons is now rather dated, its terminology reflecting the paternalistic attitude which prevailed when it was drafted. Although it does not specifically incorporate mental illness, it establishes some important principles. For example, that people with intellectual disabilities have "the same rights as other human beings,"[14] and that any restriction must accord with due process and "contain proper legal safeguards against every form of abuse."[15]

1.2.2 Declaration on the Rights of Disabled Persons[16]

The Declaration on the Rights of Disabled People was the first UN instrument to define the term "disability."[17] The

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[13] G.A. Res. 2856(XXVI), 26 U.N GAOR Supp.No.29, U/N Doc.A/8429 (1971) (MR Declaration).
[14] MR Declaration, para 1.
[15] MR Declaration, para 7.
[16] UN General Assembly resolution 3447(XXX): 9/12/75

Declaration reiterates the commitments and principles established by earlier UN instruments and reaffirms the right of disabled people not to be discriminated against. It also specifically recognises the importance of mentally disabled people's "right to inherent respect for their human dignity."[18]

1.2.3 Standard Rules

One of the major outcomes of the Decade of Disabled Persons initiative was the adoption by the General Assembly of the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities.[19] The rules do not specifically refer to mental disability. However, they do make clear the responsibility of Governments to ensure that there is legislation in place to protect and fully guarantee the equality of disabled people and to ensure that their needs are addressed in national policy.

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[17] A disabled person is defined as any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and or social life, as a result of deficiency either congenital or not, in his or her physical or mental capabilities.
[18] Declaration on the Rights of Disabled People, para 3.
[19] UN General Assembly resolution 48/96: 20/12/93. The Rules are available at www.um.org/esa/socdev/enable/dissre00.htm.

1.2.4 UN Principles for the Protection of People with Mental Illness and for the Improvement of Mental Health Care (the UN Principles) [20]

The UN Principles were the "first step in providing a global set of minimum standards for protecting persons with mental illness and improving mental health care."[21] The UN Principles emphasise the importance of quality treatment, which preserves and enhances personal autonomy. They also stress the concept of the least restrictive intervention. That is, there is a presumption that any intervention will be the least intrusive option available.

The UN Principles do not define seclusion. They do however address the circumstances under which seclusion is administered. Principle 11.11 states that "physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with officially approved procedures of the mental health facility and when it is the only means available to prevent immediate or imminent harm to the patient or others". The UN Principles do not specifically define the appropriate length of time that a person can be placed in seclusion. Instead, it is stated the seclusion time should not extend beyond what is "strictly

[20] UN General Assembly resolution 119, 46tth Session, 17 December 1991.
[21] Maingay et al, "Mental Health and human rights: The MI Principles – turning rhetoric into action" *Journal of Mental Health* 2002 vol.14, p.19 .

necessary." The UN principles also state that all instances of physical restraint must be recorded and that any patient who is secluded must be kept under humane conditions and supervised regularly by qualified members of staff. [22]

1.2.5 World Health Organisation Guidelines

The Division of Mental Health and Prevention of Substance Abuse of the World Health Organisation have provided guidance on the operation of the aforementioned UN principles.

Although not a formal publication of the organisation, the *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders* identify criteria which would ensure compliance with UN Principle 11.11. [23] The *WHO Manual on Mental Health Legislation* goes further. [24] It promotes the concept of capacity as a factor in decisions relating to treatment by taking into account the fact that a person may well be competent to consent to treatment even though they are subject to mental health law.

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[22] As a result they have been described as non-enforceable code of best practice: S Zifcak "The United Nations Principles for the Protection of People with Mental Illness: Applications and Limitations" (1996) 3 *Psychiatry, Psychology and Law* 1.
[23] WHO/MNH/MND/95.4.
[24] World Health Organisation, Geneva (2004).

The manual also suggests that national legislation should be drafted to ensure that seclusion and restraint are used: as a last resort only, for the shortest time necessary (a few minutes or a few hours at the most) and never as a punishment. It also recommends that infrastructure and resource development are promoted to ensure that seclusion is not used as a substitute for an inadequate structure or resources. Finally it states that seclusion only be used in properly accredited facilities where periods of seclusion are recorded in a reviewable register.

1.3 International Accountability and Reporting Procedures

Although the international treaties discussed do not have enforcement mechanisms, a measure of accountability is assured through specially established review processes. Each of the major treaties has a committee of experts who monitor performance and determine how well countries are complying with their international undertakings. These committees also draft general comments based on their international legal experience. General comments are considered to be the most authoritative legal interpretation of the treaty in question.[25]

[25] See Dame Elizabeth Evatt "The Impact of International Human Rights on Domestic Law" in *Litigating Rights: Perspectives from Domestic and International Law* Huscroft & Rishworth (eds) Hart Publishing (2002) at 282. For a contrary view see Scott Davidson

In 1996 the UN Committee on Economic Social and Cultural Rights issued a general statement relating to people with mental and physical disabilities[26]in which it emphasised the importance of the standard rules and the UN Principles. Although the Committee which monitors the companion treaty (the ICCPR) has not issued a general comment relating to the rights of people with mental disabilities, General Comment 18 (which relates to non-discrimination in the context of Article 7) states that the prohibition against torture and cruel, inhuman or degrading treatment applies to "medical institutions, whether public or private."[27]

A number of the international treaties also provide individual complaints mechanisms allowing people to complain directly to the relevant Committee about violations of their rights when they have exhausted all domestic avenues of complaint. The ICCPR is one of the treaties with a complaints mechanism. New Zealand ratified the optional protocol to the ICCPR in 1990. Therefore a person who considered that their seclusion

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"Intention and Effect: the Legal Status of the Final Views of the Human Rights Committee" in the same book at 306.

[26] Committee on Economic Social and Cultural Rights (Eleventh session, 1994) *Persons with Disabilities*, 9 December 1994, General Comment 5.

[27] WHO fn 3 supra at 14.

breached one of the rights in the ICCPR – for example, that it constituted cruel, inhuman or degrading treatment - has the option of taking a complaint to the UN Human Rights Committee if the domestic complaints mechanisms have proved unsatisfactory. The Optional Protocol to the Convention Against Torture also allows individuals in places of detention to complain to the appropriate international body.

The need to exhaust domestic remedies has not proved an insurmountable obstacle to complaining to an international forum.[28] For example, in A v New Zealand a person with a mental illness took a claim to the Human Rights Committee (albeit unsuccessfully) alleging that he had been arbitrarily detained under the local mental health system.[29]

[28] Although the fact there is no obligation on the part of the government to make legal aid available in such proceedings might be. See *Tangiora v Wellington District Legal Services Committee* [2000] 1 NZLR 17 (1999) 5 HRNZ 201.
[29] CCPR/C/66/D/754/1997.

2. Examples of how Human Rights Principles have impacted on Mental Health Practice in Other Countries

Although the international human rights instruments do not address mental disability, let alone issues as specific as seclusion and restraint, domestic practice is increasingly being assessed against human rights standards. This is likely to increase further if the Convention on the Rights of Persons with Disabilities is ratified in New Zealand. The following section identifies several initiatives in other jurisdictions which indicate how human rights criteria can impact on mental health policy and practice.

2.1 European Union

The European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) is a convention of the Council of Europe which came into effect in 1953. The rights in the Convention are broadly similar to those in the ICCPR, although the ECHR does not include the right to self-determination or provide for the rights of members of minority groups. In addition some of the rights

are not absolute and can be limited if 'necessary in a democratic society'[30].

The ECHR provides an international complaints procedure. It also established an international court for deciding human rights matters which has generated a considerable body of jurisprudence that acts as guidance in interpreting the ECHR. The case law demonstrates that the ECHR is increasingly acting as a benchmark for acceptable practice in relation to the treatment of people with mental disorders.[31]

2.1.1 Draft Recommendation of the Committee of Ministers concerning the Protection of the Human Rights and Dignity of People Suffering from Mental Disorder

The draft recommendation paper was drawn up by the Steering Committee on Bioethics of the Council of Europe. It is the first step in the development of a new legal instrument which will bind all member states. Prompted by reported violations of the rights of people in mental health facilities, the approach can be sourced to a specific recommendation by the Parliamentary Assembly of the Council of Europe. The Parliamentary Assembly proposed

[30] Articles 8-11.
[31] T W Harding "The application of the European Convention of Human Rights to the field of Psychiatry" *International Jnl of Law & Psychiatry* Vol.12.245-262 1989.

the development of a recommendation that would guarantee respect for the human rights of psychiatric patients.[32]

Although the proposed recommendation deals with matters broader than the administration of non-consensual treatment, addressing issues of discrimination, civil and political rights and adequate living conditions, Article 27 deals specifically with seclusion and restraint.[33] It does not differ significantly in substance from the UN Principles and recommends that seclusion should be used only infrequently for short periods, regularly monitored and its application should be consistent with the concept of the least restrictive intervention.

The explanatory memorandum that accompanies the recommendation emphasises the importance of minimising the use of seclusion. It states that it should never be used for the convenience of staff, or as a means of coercion, discipline or punishment and if seclusion is necessary "it is good practice to discuss this with the patient if it is possible to do so, and to take account of the patient's views."[34]

[32] Recommendation 1235(1994).
[33] Council of Europe CDBI/INF (2004) 5.
[34] Council of Europe CDBI/INF (2004), para 195.

2.1.2 The Third Report of the Joint Committee of the UK Parliament on Human Rights and Deaths in Custody

The Human Rights Act 1998 (HRA) made the rights under the ECHR part of UK law. This has significant implications for psychiatric patients since patients who consider that their rights have been infringed may claim a remedy under the Convention through the UK courts. In addition, courts are now required to interpret mental health legislation in a manner compatible with Convention rights as far as possible and it is unlawful for any public authority - or person acting in a public capacity - to act in a way that is incompatible with the ECHR.

Clearly rights such as the right to be free of inhuman or degrading treatment and the right to liberty and security will impact on the practice of seclusion. A number of cases which have been taken to the European court alleging violations of Convention rights (and their impact on the practice of seclusion in the UK) are described in the next section but the effect of the ECHR on the behaviour of public authorities is also evident in a number of inquiries.

The *Third Report – Inquiry into Human Rights and deaths in custody* of the Joint Committee on Human Rights of the UK Parliament included a section on the use of seclusion

and restraints. [35] While it focuses mainly on the use of restraints and the implications for breaching Art.2 (the right to life), it also provides some insight into when seclusion can breach Art.3 (freedom from inhuman and degrading treatment) and Art.8 (the right to physical integrity and private life).

In order to comply with Art.8 an action that interferes with the right must comply with established law and guidelines. It must also be for a legitimate purpose and necessary and proportionate to that purpose. For a physical intervention to be considered proportionate, it must be the least intrusive measure possible in the circumstances. This test is very similar to the concept of the least restrictive intervention found in the UN Principles.

The United Kingdom Mental Health Act 1983 does not contain provisions relating to seclusion. The power to seclude and the conditions under which it can occur are laid out in the 1983 Code of Practice. Again, the Code provides that seclusion should only be used as a last resort and for the shortest possible time. It should not be used as punishment, as a means of coping with staff shortages or where there is a risk of suicide or self harm.[36]

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[35] UK Parliament 8/12/04 available at www.publications.parliament.uk.
[36] supra at para 239.

The Code of Practice came under scrutiny following the Court of Appeal decision in R v Ashworth Hospital, ex parte Munjaz.[37] In that case it became obvious that the application of the Code varied widely, leading the Joint Committee to express concern at the "low level of compliance with the guidelines."[38] The Committee concluded that the failure to justify a departure from the Code of Practice as a necessary and proportionate response to the exceptional circumstances of a specific case was likely to lead to the responsible health authority being found in breach of the Human Rights Act and Articles 2, 3, and 8 of the ECHR.

The Committee recommended that the Department of Health take steps to ensure that health authorities were aware of their responsibilities under the Human Rights Act and ensure they are applied in practice. However, it reiterated its concern at the lack of enforcement of the guidelines in what it described as a "highly human rights sensitive area," noting that it was far from convinced that

[37] [2003] ECA Civ 1936. An appeal to the House of Lords was less supportive of consistent application of the Code. See R v Mersey Care National Health Service ex parte Munjaz [2005] UKHL 58 and comment at p 16 infra.
[38] Mental Health Act Commission and MIND quoted by the joint committee (supra) at para 240.

compliance with the Convention would be achieved without the imposition of some form of statutory obligation.[39]

2.1.3 Northern Ireland Human Rights Commission: Connecting Mental Health and Human Rights

The impetus for the NIHRC's report was the enactment of the Human Rights Act 1998 and the introduction of the ECHR into domestic law. The Commission's paper was designed to assess the extent to which existing mental health law, policy and practice in Northern Ireland complied with applicable human rights law taking relevant human rights standards into account to ensure due regard was given to the rights, interests and dignity of persons with mental health problems.[40]

As with other initiatives, the paper emphasises the "plethora of human rights concerns" that arise as a result of the ability to treat a person against their will, particularly if they are mentally capable of consent. In assessing whether legislation met human rights standards the review took as a guide the criteria suggested by the Millan Committee when

[39] supra at para 245.
[40] G Davidson, M McCallion and M Potter *Connecting Mental Health and Human Rights* Northern Ireland Human Rights Commission (2003) at 13.

considering new mental health law for Scotland.[41] The criteria (some of which resonate with those adopted by the Human Rights Commission in New Zealand for assessing policy for human rights compliance) were non-discrimination, equality, respect for diversity, reciprocity, informal care, respect for care givers, the least restrictive alternative, benefit and child welfare.

The Northern Irish report does not specifically include mention of seclusion but rather confines itself to general comments relating to treatment and consent which reflect the need to consider capacity in deciding treatment and respect for the autonomy of patients.

[41] Millan Committee *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984* Scottish Executive (2001) available at www.scotland.gov.uk/health.

2.2 Australia: The Burdekin Report and a Rights Analysis of Mental Health Legislation

In Australia the Human Rights and Equal Opportunity Commission carried out an inquiry into the rights of people with mental illness in 1993. The *Report of the National Inquiry into the Human Rights of People with Mental Illness (*the *Burdekin report)* criticised the lack of compliance of existing mental health legislation with human rights standards, as did the Reconvened Inquiry in 1995 (the *Sidoti report)*.[42]

Following the publication of the Burdekin report the Government developed a National Mental Health Strategy. As legislation varied from State to State, it was difficult to monitor from a human rights perspective. A significant component of the strategy therefore involved the development of an instrument to determine whether State legislation adequately protected the rights of people with mental illness. The indicator relating to special procedures required identifying whether the law restricted the use of seclusion and restraint along the lines of the UN Principles.

[42] The Burdekin Report recommended the establishment of protocols for the use of seclusion and that it should only be employed in the rarest of circumstances and after all other nursing strategies have been attempted without success: Page 914.

3. Relevant Jurisprudence

3.1 United States

There is a significant amount of case law on the rights of psychiatric patients in the United States. Most relates to the issue of involuntary treatment or (in the case of seclusion) is found in the context of tort law.

Constitutional challenge to seclusion and restraint has been comparatively rare but the most significant case in which it was argued was Youngberg v Romero.[43] That case remains the most important decision on the generic issue of how professional liability is assessed in institutional rights litigation. Despite this, the case has had little effect on subsequent developments in the area of seclusion.[44]

[43] 475 SC 307 (1982). The case began as a damages action on behalf of a profoundly retarded young man who suffered a number of injuries while in institutional care. The complaint against the authorities for failing to protect him was subsequently amended to include complaints about the routine use of physical restraints for lengthy periods.

[44] M Perlin "The Regulation of the Use of Seclusion and Restraints in Mental Disability Law" Professor of Law , New York Law School (paper for National Association for Rights Protection and Advocacy) available at www.narpa.org/regulation.of.seclusion.

3.2 European Court of Human Rights

The situation in the United States contrasts markedly with that in the United Kingdom where the way in which psychiatric patients are treated is being subjected to greater scrutiny as a result of the ECHR and the European Court.[45]

One of the earliest cases, A v United Kingdom, concerned a complaint about the circumstances of a patient's seclusion in Broadmoor in 1974. He alleged that the conditions of his containment amounted to inhuman and degrading treatment in terms of Art.3. The patient claimed that he had been deprived of adequate furnishing and clothing, that the conditions in the room had been unsanitary and that it had been inadequately lit and ventilated. A friendly settlement was reached with an ex gratia payment of £500 to the patient by the Government.

Perhaps the most relevant mental health case decided by the European Court in relation to the right to be free of inhuman and degrading treatment is Herczegfalvy v Austriawhich establishes the threshold that a court will apply when deciding whether treatment or behaviour breaches (Art.3).[46]

[45] (1980) 3 E.H.R.R 131.
[46] (1992) 15 E.H.R.R 437.

Herczegfalvy involved an alleged violation of Art.3 through forcible intramuscular injection of sedatives and associated use of handcuffs and a security bed. Although the Court stated that measures taken out of medical necessity cannot be regarded as inhuman or degrading, it stressed that "the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the convention has been complied with".[47] The decision also notes that when the law provides discretion to a public authority, it must indicate the scope of the discretion.

3.3 United Kingdom

Two cases in the United Kingdom have addressed aspects of policy relating to seclusion. Both S v Airedale NHS Trust[48] and R v Mersey Care National Health Service ex parte Munjaz[49] involved claims that the seclusion of the claimants was unlawful as a matter of domestic law and a breach of their rights under Articles 3 and 5.

In Munjaz the claimant challenged the nature of his seclusion at Ashworth Hospital where he had been transferred from a medium secure unit after committing various criminal offences. He did not challenge the decision

[47] At para 82.
[48] Supra fn 3.
[49] [2005] UKHL 58.

to place him in seclusion or even the length of time he was in seclusion but rather the lawfulness of the policy which he claimed departed from the Code of Practice. A fundamental part of the challenge was the review procedure adopted by Ashworth. The complainant in S v Airedale NHS Trust, challenged the reasonableness of his seclusion which took place during a period when the hospital was trying to locate a secure unit in which to place him. The Court held that the hospital's argument that seclusion was necessary because no other alternative was available was not an adequate justification but, while the seclusion was unlawful in public law terms, it did not amount to a breach of the patient's rights under Art.5 of the ECHR.

Although both Courts stressed that the safeguards in the Code were important where there was a risk that patients might be treated in a manner which contravened their human rights, the House of Lords in Munjaz considered that it was not obligatory to follow the Code. To require this was to accord the Code an authority for which there was no warrant in either the Mental Health Act 1983 or the Code.[50]

[50] per Lord Bingham of Cornhill at para 37

4. Legislative Regime Governing the use of Seclusion in New Zealand

4.1 New Zealand Bill of Rights Act 1990

One of the strongest commitments a State can make in protecting the human rights of its citizens is to embed the international standards in a Constitution and create a statutory regime to enforce them.[51]

The New Zealand Bill of Rights Act 1990 (NZBoRA) was enacted to affirm New Zealand's commitment to the ICCPR. Like the ICCPR and the ECHR, the rights and freedoms in the NZBoRA are not absolute but any limitation of a right or freedom must be able to be justified in a free and democratic society. Where there is a conflict with other legislation, the other statute will take precedence but if the legislation is ambiguous and an interpretation compatible with the NZBoRA is possible, then that interpretation is to be preferred.[52]

[51] Ministry of Foreign Affairs and Trade *New Zealand Handbook on International Human Rights* (2003)
[52] Rishworth et al. *The New Zealand Bill of Rights Act* Melbourne, OUP 2003.

On the face of it, the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH (CAT) Act) appears to prevail over the NZBoRA. However, as mental health law confers wide discretionary powers (some of which have the potential to infringe the rights in the NZBoRA) the MH (CAT) Act must be interpreted in a way that ensures this does not happen.

To challenge the exercise of a discretionary power it is necessary to establish that:

i. A right is infringed;
ii. The infringement is unreasonable and cannot be justified in a "free and democratic society";
iii. An interpretation consistent with the NZBoRA is possible; and
iv. The discretion can be exercised in manner compatible with the NZBoRA that will not render the statutory provision conferring the discretion "ineffective."[53]

This could mean that if seclusion is used inappropriately, it could be challenged under the NZBoRA. For example, a patient may allege their treatment amounts to a breach of the right not to be arbitrarily detained [section 22]. Other

[53] Supra at 118.

rights in the NZBoRA that could be relevant include the right to freedom of movement [section 18], and the right to be treated with humanity and respect for the inherent dignity of the person [section 23(5)].

While the NZBoRA has the potential to apply where mental health practices infringe human rights, it has seldom been used. This may reflect the fact that there are significant barriers to making a complaint under the NZBoRA such as the need to obtain legal aid.[54]

4.2 Mental Health (Compulsory Assessment and Treatment) Act 1992

The only specific reference to seclusion in the Mental Health (Compulsory Assessment and Treatment) Act 1992 is in section 71 which establishes a set of conditions which must be observed when a person is placed in seclusion. Although seclusion is not defined, the reference to "treatment" and the "Responsible Clinician" imply that it could be used for therapeutic purposes.

The section states that where seclusion is used it should be for as long as necessary for the care and treatment of the patient, or the protection of others and it can only take place in an approved designated room or area with the

[54] *Trapski's Family Law* MHIntro.04 at (3).

authority of the responsible clinician. The nurse or health professional with immediate responsibility for the care of the patient may place him or her in seclusion but must then bring the matter to the attention of the responsible clinician. All instances and the duration of each episode of seclusion must be recorded in a register.

Seclusion is addressed in Part 6 which deals with the Rights of Patients. Part 6 reflects the principles in the long title to the MH (CAT) Act which specifically refer to "defin[ing] the rights under which people may be subject to compulsory assessment and treatment and providing better protection for those rights." This signals Parliament's intention to ensure protection of the rights of mental health service users and highlighting New Zealand's alignment with various international instruments which recognise and protect individuals' human rights. A number of other sections in Part 6 have the potential to impact on the use of seclusion. The most obvious is section 66 which relates to the right to treatment. Section 66 states that "every patient is entitled to medical treatment and other health care appropriate to his or her condition." If the responsible clinician considers that seclusion is not conducive to a person's ongoing treatment, then arguably the service user has the option of questioning its use under section 75.

Section 75 provides a mechanism for investigating breaches of rights under Part 6. Initial referral is to the District Inspector and, if this is not satisfactory, to the Review Tribunal. Despite the section 75 mechanism, there has been virtually no litigation in the context of seclusion. This raises a number of issues including whether the MH (CAT) Act makes it difficult for service users to query substantive matters such as the inappropriate use of seclusion or whether it is the least restrictive option or alternatively, whether service users do not complain for procedural reasons such as lack of knowledge of the process or inability to access appropriate mechanisms.

4.3 Health and Disability Commissioner Act 1994

The Health and Disability Commissioner Act 1994 (HDC Act) established an individual complaints system based on a Code of Health and Disability Consumers' Rights (the Code) that was promulgated by regulation in 1996. The Code applies to "every consumer", which includes mental health patients. [55] The Code defines 10 categories of rights.

As a matter of general statutory interpretation later statutes are assumed to take precedence over earlier ones unless they specifically refer to the earlier Act. In the case of the HDC Act, clause 5 of the Code states that "Nothing in [the]

[55] Health and Disability Commissioner Act 1994 cl.1 of the Schedule.

Code shall require a provider to act in breach of any legal obligation or duty imposed by any other enactment or prevents a provider doing an act authorised by any other enactment." However, as the purpose of Part 6 of the MH (CAT) Act (Patients' Rights) is compatible with the HDC Act, the Acts can be seen as complementary. The importance of the Code in the present context is that it affirms the duty of service providers to ensure that clinical processes, including seclusion, are exercised in a professional manner, and that clinicians and mental health workers respect the human rights of patients.

A report by the Health and Disability Commissioner on the actions of a psychiatric nurse in a public hospital illustrates how the Code can apply in relation to seclusion.[56] Mr D, a 41 year old man with a mild intellectual handicap, was compulsorily admitted to hospital, sedated and locked alone in a seclusion room for an extended period of time. The clinical record documented concern about his blood pressure and previous sensitivity to psychiatric medication. The nurse going off duty gave the charge nurse coming on duty written and verbal instructions that indicated that Mr D was heavily sedated, that his breathing was strained when lying flat and that he needed nursing care to turn. Despite this the charge nurse felt that rather than rouse Mr D to

[56] Opinion 02/08692.

check his blood pressure it was more important that he slept. Mr D's health deteriorated and he died during the night.

While there seemed to be some inconsistency between the hospital's seclusion policy and the Ministry of Health Guideline, the Commissioner still held that the charge nurse's "assessment of the appropriate balance between rest and observation fell below the standard expected of a reasonable and competent nurse."[57] As a result, the charge nurse had breached Right 4(1) of the Code by failing to provide services with reasonable care and skill.

4.4 Human Rights Act 1993

The Human Rights Act 1993 is divided into a two Parts. Part 1A, which applies to discrimination in the public sector or by an agency performing a public function mandated by law, incorporates the NZBoRA balancing mechanism. Part 2 is more prescriptive and addresses discrimination in certain areas on any of the grounds listed in section 21 subject to certain specific limitations.

A complaint about seclusion is most likely to occur under Part 1A and will therefore be subject to sections 4 and 5 of the NZBoRA. It follows that, in regards to an allegation of

[57] Opinion 02/08692, p20.

discrimination in how seclusion was administered, (for example, if women were secluded more frequently than men, or people of a particular ethnicity) the practice would need to be justified under section 5 as a reasonable limitation in a free and democratic society.

However, the Human Rights Act does not only relate to discrimination, the long title to the Act refers to "the better protection of human rights in New Zealand in general accordance with United Nations Covenants and Conventions on Human Rights." This reinforces the applicability of human rights principles. To carry out this role, the New Zealand Human Rights Commission has a number of specific functions. For example, the right to carry out inquiries into law or practice if the Commission feels that it may infringe human rights.[58] The Commission also has the right to report to the Prime Minister on any matter affecting human rights including the desirability of legislative, administrative or other action to better protect human rights and ensure compliance with the standards in the international instruments on human rights.[59]

[58] s.5(2)(h) HRA 1993.
[59] s.5(2)(k)(i) HRA 1993.

5. Relationship between Seclusion and Human Rights Standards in New Zealand

On one level the statutory regime governing the use of seclusion in New Zealand complies with international human rights standards. However, the standards are necessarily generic and designed to address situations far more extreme than those occurring locally. In practice, therefore, section 71 does little more than lay out the parameters in which seclusion can occur.

The actual conditions under which it can be administered are found in guidelines of which the most important is the *New Zealand Standard: Restraint Minimization and Safe Practice*.[60] The standard, which has just been reviewed, incorporates most of the criteria that have been identified internationally as best practice.[61] However as the experience in the United Kingdom demonstrates, while a standard or policy can reflect laudable principles those principles may not always be translated into practice. It is

[60] NZS 8131:2008 Ministry of Health Wellington. For other guidelines see those listed in the Mental Health Commission's report at appendix B p.18.

[61] For example when seclusion should be used for safety rather than therapeutic reasons and its use should be reviewed and it should only be as a last resort.

worth noting that the standard stipulates that there needs to be a legal basis for each episode.

However, it is not only what legislation says and how policy applies that has implications for human rights. The way in which policy is developed is also relevant. The United Nations is increasingly relying on an approach to analysing policy which provides a useful conceptual base for identifying human rights implications of policy and practice.[62] The elements of this approach are:

- Linking decision-making at every level to agreed human rights standards;
- Identifying the relevant human rights of all involved and, in the case of conflict, balancing the various rights to maximise respect for all rights and rights holders;
- Ensuring the participation of individuals and groups affected in decision making;
- Accountability for actions and decisions which allows individuals and groups to complain about decisions that affect them adversely;

[62] United Nations Economic and Social Council (2003) *Report of the Secretary General: Promotion and protection of human rights – human rights and bioethics*. E/CN.42003/98.

- Non-discrimination among individuals and groups through equal enjoyment of rights and obligations; and
- Empowering individuals and groups by allowing them to use rights as leverage for action and to legitimise their voice in decision-making.

A human rights approach to policy development involves a change in emphasis from an approach which treats those who are the object of the policy as the passive recipients of charity to one in which they become active claimants of the right.[63] It also stresses the moral importance of the interests involved and the directory (as opposed to aspirational) nature of the duties imposed on the State with respect to realising those rights.[64]

A human rights approach also emphasises the priority of those affected by a policy in how resources are allocated. This has significant implications for the continued use of seclusion which is frequently justified on the ground that staff would resort to more draconian ways of controlling harmful behaviour such as increased medication or the use

[63] B Nolan "From Special Needs to Equal Rights: Legal Developments in the European Community in the Disability Field" (2004) 14 INTERIGHTS *Bulletin.*
[64] C Geiringer & M Palmer "Issues Paper: Applying a Rights–Based Analysis to the Development of Social Policy in New Zealand" New Zealand Centre for Public Law (2003).

of locked wards if seclusion was not available. In reality the use of such interventions is often the result of under staffing. A human rights approach would ensure adequate funding so the use of seclusion did not occur in such cases.

6. Conclusion

Laws such as the MH (CAT) Act which make specific provision for seclusion have been criticised for preserving the status quo, legitimising it as an acceptable practice and providing no incentive to reduce psychiatric control mechanisms or explore other options for care.[65] However, such criticism tends to overlook the fact that legislation can play a valuable role in protecting the rights of service users.

Given the potential for abuse of human rights, a strong argument can be made for ensuring that the use of seclusion is restricted to very limited, clearly specified circumstances. If elimination of seclusion is not ruled out entirely, then it should only be retained for extreme situations where it may be the least intrusive way of managing dangerous behaviour. The elimination of seclusion is not without precedent. For example, it is not used in general psychiatric hospitals in Scotland and it is rarely used by British mental health services.[66] In the

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[65] P Morrell & E Muir-Cochrane "Naked Social Control: Seclusion and Psychiatric Nursing in Post-Liberal Society" *Australian e-Journal for the Advancement of Mental Health* Vol.1 Issue 2 2002.

[66] See, for example, section on seclusion under "Treatment" specifically the part on Complementary and Alternative Remedies at www.mentalhealth lawyers.com at 1158.

United States three of the four regional hospital associations have the reduction of restraint and seclusion as an objective and it is not used in some State hospitals.

At present the wording in the New Zealand Act appears to imply that seclusion may be justified as a form of treatment despite international comment which suggests that it lacks therapeutic value.[67] If seclusion is used for treatment at all then it should only be where there is strong evidence of therapeutic benefit. Failing that it should only be used in cases where there is a significant threat to the patient's own safety or that of others. Arguably service users should also agree to be placed in seclusion since seclusion can amount to battery or false imprisonment unless justified by some common law or statutory power.[68] It also follows that, if seclusion continues to be used, efforts should be made to increase mental health service staff understanding of the relevance and applicability of the rights and freedoms in the NZBoRA.

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[67] There will be cases when service users will ask to be placed in a tranquil or non-stimulating environment but this is better described as "time out" rather than seclusion: L Gostin *Mental Health Services – Law and Practice* (Shaw & Sons Ltd) para 20.08A; *Report of the Committee of Inquiry into Complaints about Ashworth Hospital* Cmnd.2028 (1992) p.204.

[68] For further comment on these torts, the relevant defences and the implications for people with mental disorder see Todd (ed) *The Law of Torts in New Zealand* (4th ed) Brookers (2005) at 4.6.05.

Irrespective of how it is justified, seclusion has the potential to breach human rights. That is, patients experience the practice as degrading and humiliating, it may be used as punishment and it raises significant issues of autonomy and the right to consent.[69] A rights-based approach which recognises the importance of self-determination and autonomy and ensures that service users were treated with dignity and respect, would contribute significantly to reducing the possibility of this.

[69] Royal College of Psychiatrists "Strategies for Management of Disturbed and Violent Patients in Psychiatric Units" *Council Rep* CR 41 (1995) at 16. Studies also suggest that patients experience seclusion as negative and disempowering, complaining of lack of information, poor interaction with staff, loss of privacy and ineffective debriefing after episodes of seclusion.