Waitemata District Health Board
Best Care for Everyone

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Health Sector Workers Network
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Dear Sir/Madam

Re: Official Information Act Request – OPCAT Monitoring places of detention report 2015-2016

Thank you for your Official Information Act request to Waitemata District Health Board (DHB) received 11 October 2017 in which you sought the following:

> *In the 2015-2016 Optional Protocol to the Convention Against Torture (OPCAT) Monitoring Places of Detention report, there were a number of recommendations made to mental health inpatient units in the Auckland region. The Office of the Ombudsman's report within the OPCAT document states:*
>
> *10 recommendations were made to He Puna Waiora;*
> *Six recommendations were made to Waiatarau*
>
> *Could you please provide the details of those 16 recommendations?*

Please be aware that the Waitemata DHB Specialist Mental Health and Addiction Service serves a population of more than 615,000 within the Waitemata district and is the largest service in the country by volume of service-users seen.

The Adult Mental Health Service also provides treatment in two adult acute mental health inpatient units. He Puna Waiora is a 35-bed unit on the North Shore Hospital site and Waiatarau is a 32-bed unit on the Waitakere Hospital site.

The Crimes of Torture Act (the Act) gives effect to New Zealand's international obligations under the United Nations Optional Protocol to the Convention Against Torture ('OPCAT').

The objective of OPCAT is to establish a system of regular visits by independent international and national bodies to places of detention, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Act provides for the designation of 'National Preventive Mechanisms' (NPMs), whose role is to examine, at regular intervals, the conditions of detention and treatment of detainees and make recommendations for improvement. (*www.ombudsman.parliament.nz).*

We believe our adult mental health inpatient units (He Puna Waiora and Waiatarau) provide a high standard of care to our service users and acknowledge there are always opportunities for further improvement. We are always open to independent external feedback that can assist us to continue to improve our services for the benefit of our service-users, family and whanau within Waitemata DHB.

The following recommendations were identified by COTA during a visit to Waiatarau and He Puna Waiora and we have taken the following actions to address each finding:

Crimes of Torture Act (COTA) Report: Waiatarau		
Summary of Findings	***Recommendations***	***Actions taken in response***
1. Informal clients are being arbitrarily detained.	The practice of arbitrarily detaining clients should cease immediately.	This finding related to the fact that Waiatarau's front doors are kept locked to ensure that very unwell patients who are being compulsorily treated are not able to leave the unit. Informal patients have always been free to leave, simply by asking a staff member to open the doors for them. Notices are displayed at the reception area and on doors leading to the main ward highlighting the process for family/whanau around leaving the unit.
2. There were anomalies in both the seclusion register and restraint register	The seclusion register and restraint register should be fully maintained and accurately reported on. A quality assurance framework should be applied to the completion of all paperwork.	The service is currently developing one electronic reporting system for restraint and seclusion recording. Documentation is also reviewed at the weekly 'Restraint & Seclusion Panel' meetings and the monthly 'Restraint & Seclusion Minimization' meetings. At these meetings all documentation is updated fully.
3. Not all family/whānau are consulted as part of the sectioning process	As part of the sectioning process, the Unit records and reports on the family/whānau consultation process.	Where the service-user is sectioned in the unit, the family are contacted and this contact is recorded and documented on the HCC clinical notes.
4. Contact details for the District Inspectors were not displayed in a place easily accessible to clients.	Contact details for District Inspectors should be available next to the client telephone(s).	The District Inspectors' phone numbers are available in the phone boxes for service-users and are replaced when they are removed.
5. Some soft furnishings and carpet were damaged and worn.	Damaged furniture and worn carpets should be replaced.	There was a replacement of chairs and furniture in Waiatarau in May 2017. Replacement of carpets is underway.
6. Not all clients have access to at least one-hour fresh air daily.	All clients should have access to at least one hour in the fresh air daily. This should be recorded accordingly.	The High Care Areas and open ward have enclosed courtyards that can be freely accessed by service-users during the day.

Crimes of Torture Act (COTA) Report: He Puna Waiora		
Summary of Findings	***Recommendations***	***Actions taken in response***
1. The Seclusion register and some seclusion records were incomplete	The Seclusion register should be fully maintained and a quality assurance framework applied to the completion of all seclusion documentation (including electronic records).	The service is currently developing one electronic reporting system for restrain and seclusion recording. Documentation is also reviewed at the weekly 'Restraint & Seclusion Panel' meetings and the monthly 'Restraint & Seclusion Minimization' meetings. At these meetings all documentation is updated fully.
2. The Restraint register(s) and some documentation were incomplete	The Restraint register should be fully maintained and a quality assurance framework applied to the completion of all restraint documentation (including electronic records).	The service is currently developing one electronic reporting system for restraint and seclusion recording. Documentation is also reviewed at the weekly 'Restraint & Seclusion' meetings and the monthly 'Restraint & Seclusion Panel' meetings. At these meetings all documentation is updated fully.
3. Not all staff were up to date with mandatory training requirements	All staff should be up to date with mandatory training requirements	Staff training is routinely reviewed and where indicated staff are booked on training. Reminders regarding mandatory training, including e-learning, are sent to staff to complete.
4. The Unit is a locked facility and has the potential to arbitrarily detain informal (voluntary) service-users	Notices detailing the process for entry and exit into the Unit for informal (voluntary) service-users (and visitors) should be displayed in prominent areas, including the Unit entrance.	Notices are displayed at reception area and on doors leading to main wards highlighting process for family/whanau when needing to leave unit. The process for leaving the locked unit is accessible for visitors to He Puna Waiora to read.
5. The DHB's complaints process, including contact details for District Inspectors, is not well-advertised	Information on the DHB's complaints process should be easily accessible to all service-users. The contact details of District Inspectors should be verified and updated on a regular basis.	The District Inspectors' phone numbers are now available in the phone boxes for service-users and are reviewed regularly and replaced when needed.
6. Service-users are not invited to attend their MDT review meeting and do not routinely receive written feedback from the meetings	Service-users should be invited to attend their MDT meeting and routinely provided with a copy of the minutes of their review.	We accept the principle that service-users should, as much as possible, be involved in the planning and review of their care. Practically, however, the logistics of running such meetings with every service-user participating directly would make the running of the ward unmanageable. Input to planning and review of treatment does happen in other ways, including with family, in accord with other standards and guidelines. MDT meeting discussions are recorded in the clinical record, which can be accessed by service-users at any time should they wish to do so.
7. The DHB's guidelines for requesting Police assistance in adult acute mental health units lacks detail	The DHB should consider adopting a zero-tolerance approach on violence (to service-users, staff and visitors) by automatically referring assaults	Our usual position is that we encourage and support police involvement. However, a simplistic 'zero-tolerance' approach is unrealistic and fails to recognise the clinical complexity of acute care. Clearly, if the person affected by a violent act

	and other serious incidents to the Police. This could be incorporated into the current serious and sentinel events policy.	wants police involvement we will support that and our usual approach is to encourage and support police involvement for serious violence. However, we must be able to use our discretion on this, taking a range of factors into consideration, including views of victims and their caregivers.
8. In order to protect service-users' dignity, staff need to be more vigilant with regard to ensuring service-users are appropriately clothed	In order to protect service-user's dignity, staff need to be more vigilant with regard to ensuring service users are appropriately clothed.	Staff discuss this issue with service-users as required and encourage them to dress appropriately, while supporting individual choices. For those who are very disorganised, then staff will ensure their dignity is maintained and support them to dress appropriately.
9. Not all service-users have access to daily fresh air	Service-users need to be offered at least one hour of fresh air daily.	The High Care Areas and open ward have enclosed courtyards that can be freely accessed by service-users during the day.
10. There is no privacy for service-users when accessing the telephone	Service-users should be offered privacy when accessing the telephone(s).	There are two phone boxes available on the main wards and service-users in the High Care Areas are able to take the phone into the interview room or if using their own the bedroom. Service-users are made aware of the availability of options should they wish to take a phone call in a private space.

I trust this information will satisfy your request.

Yours sincerely

Pam Lightbown
General Manager
Specialist Mental Health & Addictions Services