considered this issue could be sorted out locally and, when issues were examined closely, there was usually flexibility.

CCDHB run Regional Forensics Services based in Porirua have recently suggested to the family of a service user that the Te Pou o te Whakaaro Nui's 'Six Core Strategies for Reduction of Seclusion and Restraint' are not part of CCDHB policy and deem the strategy recommendation for joint involvement of victim and guardian for debrief as part of a reportable event not appropriate. One of the DHB's top psychiatrists informed the family that in some instances due to physical and psychological trauma experienced by the staff involved debriefs as recommended by Te Pou where inappropriate.

Meeting Māori Mental Health Network Model of Care Update Meeting in Northland identified the issue of high seclusion rates

CCDHB and Hutt Valley DHB have demonstrated some reductions in their use of seclusion. This needs to be sustained if the overall desire, in Rising to the Challenge, of the elimination of seclusion is to be achieved.

Pleased to note that SDHB has an aim to end seclusion by 2020.

Consumer Lead from Te Pou stated that Te Pou is developing a Family brochure which provides information and what families can do. There is the question of whether there should be one for service users. Possibly the best approach would be to provide information on District Inspectors and rights. NHEW would be interested in peer-reviewing. In answer to a query the Consumer Lead said that the rate of peer debriefing varies as does opinion about whether it helps or hinders. Information on debriefing could be included in brochure on seclusion. Some DHBs picked up six core strategies and have shown reduction in level of seclusion. Maori women have twice the rate of other women for seclusion. The Six core strategies are being re-written this year and the Consumer lead would welcome peer review of them.

In Tairawhiti the goal date of ending seclusion by Feb 2020 is gaining momentum. Renovations to a closed seclusion room to become a low stimulus room has been approved and will be undertaken shortly. Plans to continue changes to the lounge are being considered along with the eventual other two seclusion rooms as they are withdrawn. There is a notable downward trend in the use of seclusion.

In the Waikato Debrief interviews continue, thematic reviews occur culminating in actions plans that prove to be a useful tool for whaiora and staff accountability. Re-think of further ways to reduce seclusion with Consumer roles having a huge influence in the conversations regarding seclusion minimization and eventual elimination.

In Taranaki the redesign of Te Puna Waiora (TPW – Intensive Psychiatric Care Unit) is ahead of schedule going into the final stage called "Rimu". Area's that have been named "Kowhai" and "Nikau" have been completed. These incorporate bedrooms with built in beds, shelving and desks, a large lounge with large TV and a sensory room called "Karakia" which also has a large TV and which will have a multi-purpose use as an interview and whanau room. The final stage, known as 'Rimu" will also include a second sensory room that will be called "Totara". There will be one commissioned seclusion room remaining. The appointment of a new occupational therapist has seen the introduction of a new ward

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programme. This runs daily from 8:30am to 3:30pm and combines a mixture of activities from arts & crafts, educational & skills groups, sensory modulation, yoga and so on.

In the Te Awakura (Acute Inpatient Service) in Christchurch four consumers experienced seclusion during February 2017 for a total of 82.8 hours

The Chair of Awareness (Christchurch Consumer) asked about the hike in seclusion statistics. Manager of CDHB mental health services said that over the holiday period there was an increase in situations where people were using substances and were secluded as a result of risk to others.

At a meeting in Dunedin for consumers to give feedback for the Human Rights and the Mental Health Act and Human Rights submission: Two individual comments from consumers on seclusion stated that Solitary confinement (seclusion) varies greatly around the country and that "Seclusion is necessary if people are causing trouble."

Seclusion Review

Thinking Outside the Box? – A Review of Seclusion and Restraint Practices in New Zealand, by world renowned expert Dr. Sharon Shalev is based on visits to seventeen different detention facilities in categories subject to monitoring under the Optional Protocol to the Convention Against Torture (OPCAT) including psychiatric detention facilities. The report gave valuable information on the legal definition of solitary confinement and noted the anomaly in referring to this as 'seclusion'. The key finding raised major concerns that contradict the glowing statistics that DHB's continue to report on.

Key findings include:

- A high use of seclusion and restraint in New Zealand and an overrepresentation of ethnic minority groups, in particular Mäori

- Some of the forms of mechanical restraint used were inherently degrading to the individual. Of particular concern was the use of restraint or tie-down beds in prisons and the use of restraint chairs in police custody.
- Stark physical environments and impoverished regimes in seclusion, secure care and segregation units, and in a number of cases no access to basic fixtures such as a call-bell to alert staff, a toilet or fresh running drinking water.
- Access to basic entitlements including daily access to a shower and an hour long exercise in the fresh air were not always guaranteed.
- The physical design and material conditions in the so-called 'At Risk units' in prisons, where vulnerable prisoners were housed, were mostly identical to those in other solitary confinement units. These units may be contrary to international standards which prohibit the placement of prisoners with physical or mental disabilities in solitary confinement.
- Children and young people in Care and Protection residences could be held in separation from their peers in 'Secure Care' units which were identical to prison segregation units. These were inappropriate.
- The deprivation of social interaction which is inherent in all solitary confinement practices was often made worse by the deprivation of other provisions which could have helped to mitigate the harmful effects of seclusion. These included restrictions on family visits and in-room provisions such as books, hobby and craft materials or a TV set.
- A small but persistent number of people in health and disability facilities were subjected to

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very long-term restrictive measures, and discussion of future plans for these individuals appeared to be focused on variants of seclusion and restraint. For the individuals concerned, prolonged seclusion and /or restraint (and often both) had thus become a chronic state rather than an emergency short term response to an acute situation.

- Review processes were not always robust, and some stays in restrictive conditions were far too long.

Several service users provided written and oral submissions to Dr. Shalev

Employment

In Dunedin there is a working group to get people into some form of employment, we have had one public meeting at WINZ and a good turnout of Consumers and people in the right areas to help guide them forward. I was a key speaker from a Consumer into full time paid employment after six years out of work, proving it can be achieved.

They are now putting in place resources to run Focus groups in rural areas and in Invercargill to gain feedback on the Service as a whole, we hope to gather information which will lead to even better outcomes for Consumers, Youth and Families.

Employment discrimination

A peer has reported being concerned at being asked for a passport when applying for employment within a government department.

There is concern that not only does this provide opportunity to overly scrutinise a persons disclosures around citizenship, it is also has gives employers the ability to discriminate on the grounds of age due to the information on the passport.

A person in the Wellington region told a clinician that she was a Social Worker at a peer organisation and she was a former client of Drug and Alcohol Services. The clinician expressed surprise and said she thought that it was totally inappropriate that the person should be working one to one with service users. The Social Worker said that this was an example of overt discrimination.

Homelessness and begging

There has been concern generated throughout the country regarding homelessness and begging. In some places there have been calls to ban begging by councils. A novel way of working with this project has been the Peoples Project in Hamilton.

The Peoples Project - Hamilton

The People's Project has adopted the Statistics New Zealand definition of homelessness:

"Living situations where people with no other options to acquire safe and secure housing: are without shelter, in temporary accommodation, sharing accommodation with a household or living in uninhabitable housing."

For some people, homelessness means sleeping rough on the street or living in cars. For others, it could involve couch-surfing or house-jumping with friends or acquaintances.

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Why are people homeless?

Everybody has a different story

Until recently, most of us probably thought of homeless people as those living on the streets. While this situation still exists, the number of people sleeping rough on a regular basis is relatively small.

The fact is, there are different forms of homelessness.

Types of homelessness

Transitionally homeless = 80%

Episodically homeless = 15%

Chronically homeless = 5%

Chronically homeless definition

We estimate the number of long-term, chronically homeless people, who have spent more than a year on the streets, is as little as five per cent of the homeless population. Of course, one person sleeping on the streets is one too many. In Hamilton, this number represented around 80 hard core 'streeties', almost all of whom are now in homes. (*Reference:* Withheld under [section 9(2)(a)], *Founder, Pathways to Housing.)*

Homeless urban myths

Separating fact from fiction

When we started working with homeless people, we quickly realised that there were some big myths out there. All of which, we can put right.

Don't people choose to be homeless?

We have not yet met any homeless people who truly wanted to live on the street. Living on the street is dangerous. Homeless people are often abused and attacked, discriminated against and alienated. They are often sleep-deprived, under-nourished and unwell. It's cold, dirty and humiliating living on the street. Many are there because they simply cannot see another way of dealing with things. Every one of the homeless people we work with wants a home. Most also want work.

Don't people need an address to get a benefit?

Every person correctly registered with Work and Income can receive a benefit. The People's Project makes sure everyone is receiving their entitlement. That said, many are living on less than $100 a week. Many have overwhelming debts and fines.

Aren't all beggars homeless?

Worldwide it is recognised that the majority of beggars are not homeless. In Hamilton, we identified 15 beggars in the central city, none of whom were homeless.

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Research shows that the majority of money received from begging is used to fund people's addictions. While there's a feel good factor for some people in dropping money into their begging cups, it doesn't actually assist people at all. The public needs to know that when people are begging and saying they're homeless, that's not necessarily accurate.

Homelessness can't be fixed, can it?

There are communities worldwide who are close to ending homelessness. They have done this by adopting a Housing First Model and focusing on ending homelessness rather than managing it. They have done this by collaboration across communities and co-ordination of mostly existing community resources. Worldwide, developing a stock of safe, affordable housing has been key to success. Wellington City Mission also works in a similar way to DCM.

Homelessness in Wellington

In Wellington there is a group called Downtown Community Ministry (DCM) that specialises in working with people who are homeless in this region. They provide total money management and many people have their benefits paid into the bank account of DCM. They also provide a food bank

Youth homelessness

Anecdotally they are an invisible homeless population, undercounted for years, hiding out in cars and abandoned buildings, in motels and on couches, often trading sex for a place to sleep. And now, for a complex variety of reasons, the number of youth — teens and young adults — living on the street appears to be growing.

Young homeless people are at risk for a host of troubles with long-lasting impact, including substance abuse, mental health problems and physical abuse, as well as sexual exploitation. Many get caught up in the criminal justice system. Up to 40 percent of homeless youth are lesbian, gay, bisexual or transgender.

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Suicide

Everyone knows already that the suicide rate in New Zealand is still too high. Ministry of Health research found that 80% of people in the southern region who have suicided had been in contact with mental health services in the last 12 months. Mental health services need to change to be more consistently responsive and available to people in crisis. The supportive attitude of mental health services staff to people in crisis is crucial.

- **From a general perspective, there are specific groups which are more at risk**
  E.g. Maori, Youth, Pacific people, Men, Drugs and Alcohol, LGBTI, Mental Health, Elderly. As well people who have been bereaved by suicide are at risk to also attempt or complete suicide.
- **Focus areas to strengthen mental health and suicide prevention literacy education .**E.g. Churches, Schools, Community Houses and Groups, Rural Businesses, Urban Businesses, Hospitals, Mental Health Professionals, Domestic Violence workers.

- **Some general actions and systems could we improve to support communities, family, whanau in distress and at risk of suicide/prevent suicide or self-harm behaviour are:**
  NGO partnerships, Mapping processes between services, Health Education, Well-being campaigns, Support Programmes, Building Awareness, Promoting the positives, Policy and service Improvements, Age groups, especially people aged 60+
- **Targeted actions that would seriously minimise suicide and suicide attempts:**
  Greater efforts by Oranga Tamariki to better support young people who have fallen out of the health system, education system and even by the welfare system. Greater attention for elderly who may need support to remain in their homes as well as protection from domestic violence or financial abuse.

- **Focused actions that are required to better support family/whanau/ communities when impacted by suicide and individuals after self-harm behaviours (post self- harm, postvention and bereavement)are:**
- Talking therapies, etherapies', specific well trained leaders of support groups, upskilled mental health workforce

Latest statistics for MidCentral DHB, indicate in the last reportable year, 2015, there were 166 suicide attempts and acts of self-harm at Palmerston North Hospital's ward 21 inpatient psychiatric detention facility compared with only 12 in 2012, although officials reported in the media say "only one person alone was responsible for 62 acts of self-harm and 13 suicide attempts"

Withheld under [section 9(2)(a)] whose brother Withheld under [section 9(2)(a)] took his life at the Palmerston North hospital ward Withheld under [section 9(2)(a)] has been in touch with the writer to raise concerns at the follow up to the family's complaint. Responding to the latest suicide statistics Withheld under [section 9(2)(a)] said all incidents should be treated seriously, as if they were an actual suicide. Withheld under [section 9(2)(a)] is reported in the local media as saying "attempting to make the number look smaller by attributing heaps of events to an individual is a 'cop out'. Surely, if it's one person creating lots of events this shows their treatment is not working." Withheld under [section 9(2)(a)] said reports from the ward had commented adversely on its atmosphere. "All have said the environment is not safe and non-conducive of supportive treatment." A service user who has recently had a long stay at the detention facility informed the writer last week of an estimated 95% of people at the detention facility would only speak negatively about the service.

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Costs of Transportation

Transport can be an issue with the encouragement of service users being independent they often struggle financially. Cost of bus fares, use of the disability van the fare has increased, as have half fares in taxis due to physical as well as mental health issues. Key Workers help to fill that transport need, but there is the question: do we give them transport or encourage more independence in the community. balance

1.9 Overview of areas of best practice in the Mental Health and Addictions sector

New Emergency housing in the Hutt Valley

Oasis network now has 15 beds for emergency housing for men who experience mental distress / illness and or addiction with 'low to moderate' needs.

- The Hillary Court facility is a newly renovated complex in central Naenae.
- Facilities include:
- Fifteen fully furnished single and double rooms
- Large open dining / living spaces on each floor
- Large flat screen TV in each living space
- Fully equipped kitchen
- Showers and toilets on each floor
- Laundry facilities on each floor
- Please note that there is no lift.
- Supergrans support for learning to cook new recipes and budget well

Who can be a resident?

Single men who:

- want to get into permanent housing
- have low to mild mental health and/or addiction support needs
- register on the housing register held by Work and Income NZ are able to live communally with others in Oasis' Emergency House
-

In Kapiti Wellington, Mayor and Councillor have set up a housing committee to focus on the immediate and long term needs of providing a range of housing including emergency and social; adapted for disabled; single; and families

Emerge housing project – up to 300 families to be housed over the next 2 years. 70 units for families for 12 weeks. They will be WINZ clients, in need of emergency housing. Referred to the housing team and onto a waiting list. They have started in Tawa.

Impact of NHEW

The Information Provided by NHEW to the Ministry of Health

- NHEW work supports the Ministry of Health (MOH) to respond to the issues people receiving mental health and addiction services face in a timely manner. This information is directly from people using services and includes NGO's and their clients and so cannot be sourced from the reporting District Health Boards. Because it is sourced from people with lived experience it is invaluable.
- MOH is able to use the information provided by NHEW to inform policy, procedure and new developments. NHEW gives the ministry an insight into what matters to the people who are effected by the decisions made at ministry level.

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- NHEW reports are distributed throughout the ministry and sent to the Director of Mental Health's office.
- The integrity of NHEW's work means that the group is a ready resource for gaining the viewpoint of people with lived experience for example: the external reference group for 'Rising to the Challenge' and for ministry interview panels. Also quarterly reports keep the ministry in touch with what is happening in service user's daily lives.
- The MOH sees worth in the work that NHEW is doing. Especially the networking of groups such as NHEW with SF, Platform and other service user interest groups.
- Many opinions and standpoints, give the Ministry a more rounded picture of what is happening for people with lived experience in the sector.

E-Network

The NHEW E-network continues to grow. Requests are now coming in for NHEW to send out information through the network on behalf of others. Members are utilising their business cards as a means of growing the network. NHEW has no way of knowing how far and wide the E-network reaches. Work will continue on increasing the network and sharing information.

Website

The Nga Hau e Wha website is a work in progress. We have now done all the work to retrieve the contents of the webpage that was on the Lakes DHB website and we have a new website of our own up and running. We now have on the website information that was on the old one that was under Lakes DHB and we are continuing to add to the content. (www.nhew.org.nz)

Bulletin

NHEW has intentions to produce a regular bulletin of highlight items from the minutes and regional reports which are of specific use to those in our networks. The intention was to send out to e-networks and place on the website. Unfortunately our human resource does not have the capacity to do this work currently. Minutes from NHEW meetings will continue to be posted on the webpage and sent out via the network.

HPA Changing Minds contract

HPA, Changing Minds Nga Hau e Wha and other partners have been awarded the Lived Experience Leadership Initiative contract. Nga Hau e Wha will be providing links, networks and contacts to enable the project to reach the audiences which are people with lived experience. The project will also enable Nga Hau e Wha to grow and strengthen their networks.

1.10 Changes or developments that have come out of Rising to the Challenge.

The Mental Health and Addictions Workforce Development Plan has been created as an action out of 'Rising to the Challenge'. NHEW is represented by its Chair on the Expert Leaders Group

National Association of Mental Health Service Consumer Advisors

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Ongoing discussions have taken place with NAMHSCA and we are informed that they are still in the process of drafting an MOU for our two organisations. We have invited their Chair to our next meeting in August

Regional Updates

Nga Hau E Wha

"Champion many voices"

Representative: **Jak Wild**

Central (North) Region: **MidCentral DHB / Hawkes Bay DHB / Whanganui DHB**

Meeting date: **23rd /24th February and 25th / 26th May 2017**

Networking update

Introduction:

Networking

Although new persons have been identified to include in our local distribution list and contacts have made with a number of peer leaders that have been identified to me in my new role, there has been poor response top contacts made and little opportunity to further collaborate.

A strategy to develop relationships is being worked on such as increased face to face meetings, attendance at hui's, and regional promotion of Ngā Hau E Whā to increase presence and collaboration with peer leaders, local peer groups and other networks that peers are active with in the north of the Central Region.

One-on-one meetings with service users provided most of the detail for this quarters report including the reports of inpatient service provision

A schedule of visits by Victoria and Jak (the writer) to services in Levin and Palmerston North has helped establish valuable relationships with service users and the services they use.

Notably Mana o te Tangata Trust, which provides peer support and day activities from their centres in both Levin and Palmerston North. Visits to both the Levin and Palmerston North services will continue to be undertaken regularly so as to engage service users formally at the services 'Consumer Engagement Forum' meetings as well as an opportunity to meet services users one-on-one.

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There were poor responses to repeat contacts with Mental Health and Addiction Services in other regions, including Hawkes Bay and Wanganui. For the next quarters report, on-site visits will be scheduled for Hawkes Bay and Wanganui services, in an attempt to follow the success we have had with Levin and Manawatu services.

1. Issues/challenges identified by people in your region

Mental health services and autism

- Concerns are often raised within our networks at the lack of access to mental health services for people on the autism spectrum

- A peer who is active in the Autism networks and who has lived experience of Autism both as an autistic and a parent, and as an advocate for other autistics provided the following written report (personal details have been redacted):

The area of mental health and autism is hugely concerning.

1. We are often denied access to mental health, on the basis that we are autistic. This is quite frankly a form of discrimination – saying our impairments prevent us from getting mental health help. I am sure that this would breach our human rights in accessing health care. This means that autistics struggling with mental health will either not seek help or if they do and are denied may take drastic action. Lack of mental health care could potentially result in deteriorating mental health resulting in compulsory care being required.

2. If, due to our Autism, we have a meltdown resulting in violence this can result in us ending up in one of two (bad) places:

Seclusion (where our basic human rights are denied- as in the example of a high profile case of an autistic man living long-term in a lower north island psychiatric detention facility)

The criminal justice system (where not only may our basic human rights be denied but we are also likely to face considerable difficulty in accessing help and it may be totally inappropriate for an autistic child (as in the example of recent case of 14 year old boy who ended up in jail as no other suitable accommodation could be found – link here

<Lack of appropriate autism services and supports for those with high and complex needs>).

The case referred to above of the autistic man living long-term in psychiatric detention has resulted in cruel and inhumane treatment including:

- major dental trauma/physical health issues which took too long to be acted on

- denial of visitation rights

- denial of parental rights (many parents are not really away they lose their rights

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under compulsory care. And in their case they were essentially told "he is ours now"

- isolation

- increased mental health issues

- not being valued or treated with dignity

- loss of all rights, freedoms and opportunities for a number of years

This situation creates fear for many other parents and their autistic children. I am aware of parents who have fought hard to keep their (adult) autistic children out of seclusion.

I am aware of a $19million pilot programme on mental health being conducted at Rimutaka so this may help though the results remain to be seen.

3. There is no guarantee that in seclusion the correct mental health 'help' will be given. In the case referred to above case the persons parents ended up paying thousands of dollars to get experts in to correctly diagnose their son.

4 Even with strong peer and other advocacy Autistics (and likely others with mental health conditions) can struggle to assert and be granted their human rights. The Human Rights Commission (HRC) commented on this in regards to the case detailed.

5. The Optional Protocol gives no legal redress retrospectively

Another Autistic person I have spoken to with personal experiences of seclusion stated:

- He was never punished there and for him it resulted in his epilepsy being diagnosed and treated

- He saw others punished there (with electric shock therapy)

- He was threatened sexually and reacted with violence. Fortunately not punished.

- He grew up in a home with physical abuse, for him seclusion was almost a refuge.

- Despite or perhaps because of his experiences the person has fought very hard to keep his autistic son out of seclusion.

Habeas corpus cases for illegal detention

Dr. Withheld under [section 9(2)(a)] has continued his ongoing court action detailed here in support of disabled people, with recent claims for compensation and habeas corpus for three persons who have been deemed to have been illegally imprisoned in psychiatric facilities. The 3 cases, recently came before the Wellington High Court with claims that conditions in psychiatric facilities equated to 'disproportionately bad treatment' and essentially that the 3 persons were held in 'private prisons'. The class action highlights what Dr Withheld under [section 9(2)(a)] and his supporters see as the discrepancy between disability rights enshrined in the UNCRPD and NZ BORA and contradictory domestic legislation such as the Mental Health Act and Intellectual Disability Act.

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