Human Rights and Clinical Psychology

A Comment on the Human Rights Commission's 2016 Review of Seclusion & Restraint in New Zealand

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Foundations of Practice

The New Zealand Code of Ethics for Psychologists (2002), a document upon which the values of the profession of Clinical Psychology have been built, fundamentally commits the profession of Clinical Psychology to upholding the rights of individuals to freedom, self-determination and dignity (including freedom from inhumane or degrading treatment).

While there remains little scientific evidence to support the *therapeutic value* of seclusion and/or restraint (in different forms) in health, social care, education or criminal justice settings, it remains in common practice across New Zealand and across the World- most typically justified as a method of managing clinical risk (the person's risk to themselves or to others). In contrast, there is growing consensus that the practice of seclusion and restraint significantly impacts upon the dignity and individual rights of the person.

> *"After decades of research and debate, these polarised views have reached a degree of consensus. Most would now agree that seclusion is potentially harmful, contradictory to recovery models of care, and surrounded by serious ethical and moral issues."* Mental Health Commission, 2004

Given this consensus, and the Ethical Code for Psychologists, the New Zealand College of Clinical Psychologists (referred to in this document as 'the College') strongly supports the positions of our colleagues from Australia (Australian Psychological Society, 2011) and from other professions in New Zealand (e.g. New Zealand Nurses Organisation; Cited in Hagan, Divis and Long, 2008). That is, the College is strongly committed to the elimination of seclusion and complete minimisation of restraint, in all of its forms. For this reason, we strongly endorse the work of Te Pou (e.g. O'Hagan, Divis & Long; 2008) and the Ministry of Health (2008) in working towards this goal.

There is clear research evidence to show that restrictive practices are often disproportionately applied to individuals from minority groups- in the New Zealand context, particularly men from Maori and Pasifika backgrounds (McLeod et al, 2013). Similarly, the College is aware of strong evidence that restrictive practices- particularly the use of so-called 'chemical restraints' (the use of psychotropic medication to sedate an individual) are disproportionately utilised with individuals with disabilities, where their usage is significantly influenced by staff members' *perceptions* of potential threat (e.g. client Body Mass Index, perceived client mobility; Robertson et al, 2000). These patterns are of considerable concern to clinical psychologists- going to the heart of the profession's commitment to issues of social justice and the Treaty of Waitangi (Code of Ethics for Psychologists, 2002)- and, we believe, require a greater focus on both the individual and the policy level.

Psychological Alternatives to Seclusion and Restraint

Most professional guidelines recommend that seclusion and/or restraint should be considered as *techniques of last resort only.* This being the case, the College would argue that services would need to demonstrate that they have actively and meaningfully explored *all* potential alternatives to seclusion and restraint (e.g. Ministry of Health, 2008)- including, amongst them, proactive psychological approaches to managing clinical risk and client care, that take into account the cultural, mental health and disability support needs of the service user.

> *"If you are going to restrict patients, care needs to be of a high quality and, to put it simply, the care component of detention leaves a lot to be desired. Everyone, not just in forensics, needs to have access to psychology- not simply added to the waiting list. Years ago I could have done with my emotional (not just medical) needs being met."*
> -Service user on forensic ward for women, Care Quality Commission Presentation 2013
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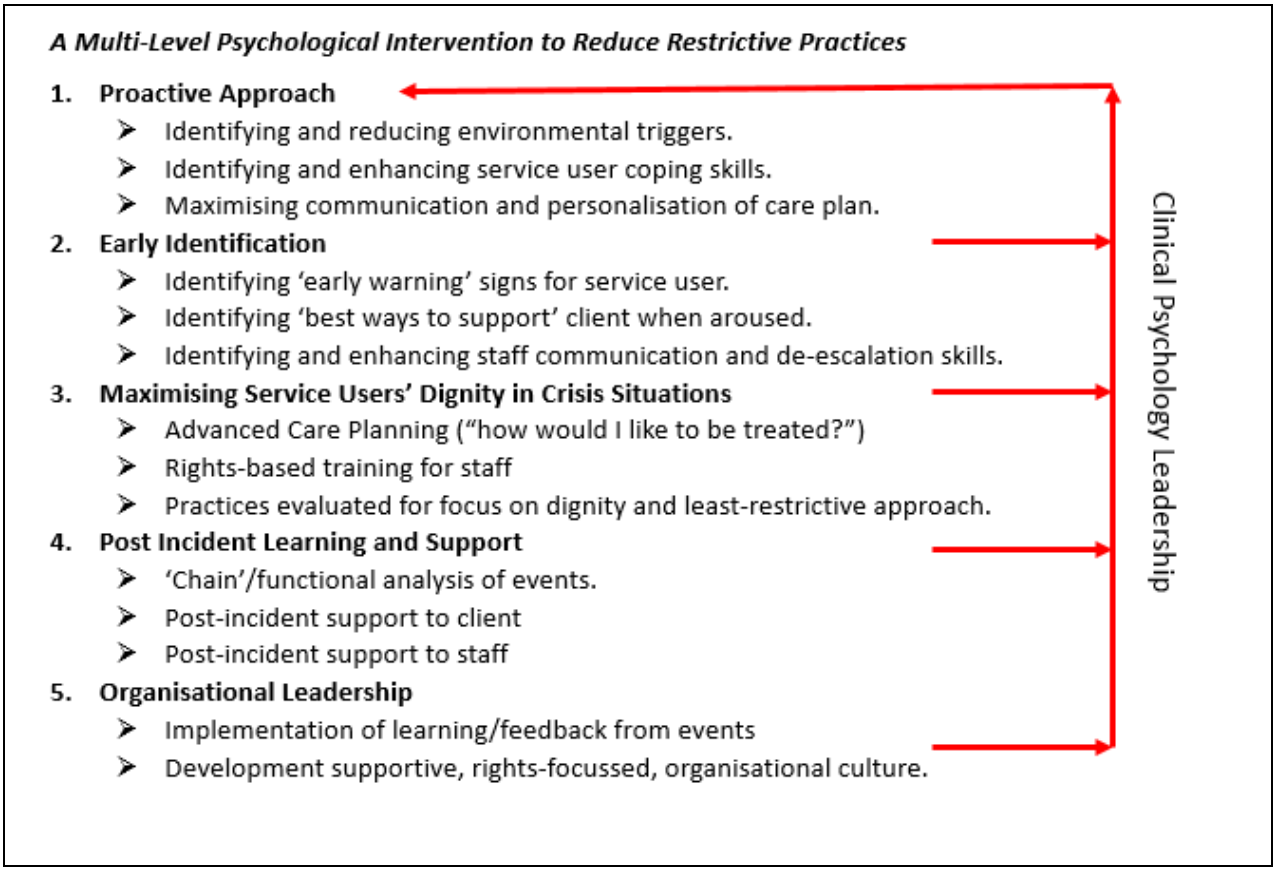
> *"I don't think I got proper counselling to begin with, in the very instance that I was admitted. And this is probably what is so crucial, imperative, to get one-to-one counselling and really talk it through… I think counselling's the most essential thing, you know? Without it, patients are lost. 'Cos then they're gonna be kind of lost, they're gonna be constantly lost, and then pumped with more medication that they don't need."*
> -MH Service User; Cited in Chambers et al, 2014.

The factors that lead up to an individual seclusion or restraint event are typically highly complex and inter-related; including the psychological and physical characteristics of the service user, the staff, the physical environment and the prevailing service culture (e.g. Australian Psychological Society, 2011). In this regard, we believe that clinical psychologists, with their training in multi-factorial formulation[1] of mental distress, are vital in supporting services to work towards restraint- and seclusion-free practice.

The Australian Psychological Society (2011) has provided some key guidance on managing risk and minimising restrictive practices, including seclusion and restraint, particularly in services for people with intellectual disabilities, and describe a number of important psychological approaches. Amongst these, individual interventions with clients (e.g. psychological skill building, pre-crisis care planning, post-incident debriefing), with staff (training in de-escalation techniques, specific clients' psychology, providing post-incident support), completing root-cause analyses of incidents (e.g. 'chaining' or functional analysis) and organisational leadership/culture change are all considered important in minimising the use of restrictive practices, and these align with those prescribed by Te Pou (e.g. O'Hagan et al., 2008). While these interventions might, individually, be provided by other professions, we would argue that Clinical Psychology has particular advantages in this field as it is able to provide *all* of these interventions in a fully 'joined up,' systemic, culture-sensitive and person-centred manner.

[1] 'Formulation' is a term commonly utilised in clinical psychology, to describe a psychological explanation of a persons' key presenting difficulties and suggesting the best areas for intervention. A clinical formulation would typically involve multiple factors, including individual, environmental and interpersonal aspects of an individuals' psychology.



Rights-Based, Recovery-Focussed and Formulation[1]-driven Approaches

Formulation Driven and Recovery-Focussed

As noted above, the reasons behind each individual seclusion or restraint event occurring are likely to be complex, multi-factorial and highly individual; based upon characteristics of the service user, the staff involved and the organisational/environmental context. For this reason, the College suggests that a clear formulation and plan, based on psychological principles, and aimed at; a) reducing potential/further seclusion/restraint events and b) maximising the service users' dignity and ability to self-determine; should be developed collaboratively with mental health service users and their whanau. In 'high risk' populations in particular, we believe that clinical psychologists are best placed to take the lead in developing these types of evidence-based plan (e.g. Whitehead, Carney & Greenhill, 2011).

A Rights-Based Approach

As noted above, Clinical Psychologists are bound by their Code of Ethics to show respect for the dignity of persons and peoples, *in all circumstances*. Whilst Mental Health, Intellectual Disability and Common law are utilised to *restrict* an individual's rights to self-determination, no legal statute can be used to *completely negate* an individuals' rights to self-determination or to dignity. In our view, the balance between self-determination and risk management are frequently presented as a false dichotomy- suggesting that individuals forfeit their right to dignity and self-determination, due to their risk to themselves or to others.

For this reason, a number of authors have recently called for the balance to shift in Mental Health services towards rights-based planning and delivery (e.g. Porsdam Mann, Bradley & Sahakian, 2016).

While human rights are considered innate and universal, the ability of individuals to exercise these rights can vary considerably, based upon their background (culture, upbringing, education, (dis)ability) and current context (e.g. poverty, homelessness, poor mental health). Focussing on the rights of the individual, rather than the response of the system, has been found to yield consistently positive results- including increasing client and staff satisfaction, reducing restrictive practices and 'risk aversion' amongst practitioners, and a reduction in inequity of access to health services (Porsdam Mann, Bradley & Sahakian, 2016).

One study of importance, led by UK Clinical Psychologists in the Intellectual Disabilities field (Whitehead et al., 2011), was shown to result in a significant reduction in seclusion and restraint, following a comprehensive, person-centred, formulation-driven and human-rights based approach to high-risk individuals. The authors have also written elsewhere about their approach to informing service users of their rights and working together on co-design of services (Roberts et al, 2012; Roberts et al, 2011; Greenhill & Whitehead, 2010) and similar findings are presented in numerous studies reviewed by Porsdam Mann and colleagues (2016).

Summary and Conclusions

- The New Zealand College of Clinical Psychologists support the views of our colleagues from Australia (Australian Psychological Society, 2011) and from other professions in New Zealand (e.g. New Zealand Nurses Organisation; Cited in Hagan, Divis and Long, 2008), in our commitment to the reduction and absolute minimisation of restrictive practices, including seclusion and all forms of restraint.
- The reasons for specific seclusion and restraint events are likely to be highly individual, and will based upon a complex interaction of the characteristics of the service users, the staff members involved, the organisational and environmental context.
- We consider that the skills of Clinical psychologists, with their training in understanding complex behavioural interactions, are extremely important in a) assessing and formulating the reasons for restraint and seclusion events and b) providing alternatives to restrictive practice through proactive and reactive support to clients, staff and service managers.
- Clinical psychology-led rights-based approaches to complex risk management- with a strong emphasis on individualised and person-centred formulation and a 'recovery' focus- appear to show significant promise in reducing seclusion and restraint in vulnerable populations.
- The disproportionate use of restrictive practices with minority groups- including those with disabilities, and those from Maori and Pasifika backgrounds in New Zealand- is of significant concern. Based on the above evidence, the College suggests that human rights-based approaches, with their focus upon inalienable rights of the individual (regardless of background) show some significant promise in addressing institutional discrimination.

References

Australian Psychological Society (2011). Evidence-based guidelines to reduce the need for restrictive practices in the disability sector. Sydney, Australian Psychological Society.

Care Quality Commission (2013). "You don't Address Quality of Life with Meds." What people under the Mental Health Act told Regulators. Slideshow retrieved 28/11/2016 from: http://www.slideshare.net/comcareandy/cqc-mental-health-act-quotes

Chambers M, Gallagher A, Borschmann R, Gillard S, Turner K & Kantaris X (2014). The experiences of detained mental health service users: issues of dignity in care. BMC Medical Ethics 15:50

Greenhill B & Whitehead R (2011). Promoting service user inclusion in risk assessment and management: a pilot project developing a human rights-based approach. British Journal of Learning Disabilities, 39: 277–283

Mental Health Commission (2004). Seclusion in New Zealand Mental Health Services. Wellington, Mental Health Commission.

O'Hagan M, Divis M, Long J. (2008). Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change. Auckland: Te Pou Te Whakaaro Nui: the National Centre of Mental Health Research, Information and Workforce Development.

Porsdam Mann S, Bradley VJ & Sahakian BJ (2016). Human Rights-Based Approaches to Mental Health: A Review of Programs. Health & Human Rights 18(1):

Roberts, A., Greenhill, B., Talbot, A. and Cuzak, M. (2012), 'Standing up for my human rights': a group's journey beyond consultation towards co-production. British Journal of Learning Disabilities, 40: 292–301

Roberts, A., Townsend, S., Morris, J., Rushbrooke, E., Greenhill, B., Whitehead, R., Matthews, T. and Golding, L. (2013), Treat me Right, Treat me Equal: Using National Policy and Legislation to Create Positive Changes in Local Health Services for People with Intellectual Disabilities. J Appl Res Intellect Disabil, 26: 14–25

Robertson, J ; Emerson, E ; Gregory, N ; Hatton, C ; Kessissoglou, S ; Hallam, A (200). Receipt of psychotropic medication by people with intellectual disability in residential settings. Journal of Intellectual Disability Research 44 (6): p. 666-676

Whitehead R, Carney G, & Greenhill B (2011). "Encouraging positive risk management: Supporting decisions by people with learning disabilities using a human rights-based approach." In R. Whittington and C. Logan (eds), Self-harm and violence: Towards best practice in managing risk in mental health services. Chichester: Wiley Publishing