Oversight

Investigation Report

An investigation into the Ministry of Health's stewardship of hospital-level secure services for people with an intellectual disability

July 2021

Peter Boshier
Chief Ombudsman

Ombudsman
Tuia kia ōrite · Fairness for all

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Published in July 2021
By the Office of the Ombudsman
PO Box 10152, Level 7, SolNet House,
70 The Terrace, Wellington

ISBN 978-1-99-115264-0 (online)

Document available online at
www.ombudsman.parliament.nz

Contents

Foreword

In January 2019, I commenced a self-initiated investigation into the role of the Ministry of Health – Manatū Hauora (the Ministry) in relation to the facilities and services provided for people with an intellectual disability who are subject to the High and Complex Framework (the Framework). The Framework is for people with an intellectual disability who are supported in secure or supervised care, either in a hospital or in the community. Framework services are delivered by District Health Boards (DHBs) and non-governmental organisations, under contract to the Ministry.

As steward and kaitiaki of the health and disability system, the Ministry is accountable for taking a whole-of-system approach to ensuring that the Framework functions effectively. My investigation arose from two primary concerns: a continuing shortage of specialised hospital accommodation for people with an intellectual disability requiring secure care and rehabilitation; and the conditions in which some people were being detained.

During my investigation I obtained information from the Ministry, DHBs, and other relevant parties. I did not investigate providers of Framework services or the care they delivered. Rather, my focus was how the Ministry was administering the system as a whole, and ensuring that the rights of people subject to the Framework were upheld. Although I did not investigate individual cases, I was committed to ensuring that my investigation included the voices of people supported under the Framework, and their whānau. My investigation team met with a number of service users and their support people, to hear about their experiences. Some of their stories have been incorporated into my report to illustrate the systemic issues I have identified.

I have found that the Ministry did not respond in an effective or timely manner to concerns that hospital-level services were running at full capacity. High occupancy levels have delayed legal proceedings and required alternative, suboptimal placements for some service users.
There is also a group of service users whose needs were not fully anticipated when the Framework was established. Not all service users with complex or highly individualised support needs have had the best opportunity to develop their capabilities and strengths, to be supported in a less restrictive environment, or to transition into the community. The experiences of some of these service users have been traumatising and have impacted negatively on their wellbeing. Their rights under relevant legislation and the United Nations Convention on the Rights of Persons with Disabilities have not always been upheld.

Overall, I have found that the Ministry failed to effectively plan, take action, or monitor Framework services. I have also found that the Ministry did not provide good quality, robust advice about Framework issues. In sum, I have found that the Ministry did not take reasonable steps to discharge its stewardship accountabilities. I have called my report 'Oversight' to highlight my view that the Framework, and the people it serves, have not had adequate oversight by the system steward.
I have made a number of recommendations intended to strengthen the Ministry's stewardship of the Framework.

I wish to acknowledge that the Ministry operates in an inherently complex and changing environment with competing priorities. I am aware that for the last year of the period I looked at—January 2015 to December 2020—the COVID-19 pandemic presented significant challenges for the Ministry. Further, in response to the Health and Disability System Review, the Government has decided to consolidate all DHBs into a single agency known as Health New Zealand, with decisions about disability support services yet to be confirmed. I acknowledge that future structural changes to the health and disability system may impact on the Ministry's approach to implementing my

recommendations. However, I note the strong thematic alignment between my recommendations and the sector reforms—to strengthen the Ministry's role as steward, and to ensure that responsibilities and accountabilities are clearly defined.

I also wish to acknowledge that the Ministry has taken some steps towards improving hospital- and community-level capacity and services. As part of this, the Ministry is progressing options for further investment in Framework capacity and capability. It is essential that the Ministry collaborates with all the relevant parties to develop a clear roadmap for the way forward. The Ministry must do more to ensure a system that enables Framework service users to lead more independent and fulfilling lives.

I have been heartened by the sheer dedication of health and disability professionals who provide care and rehabilitation to Framework service users. I would like to thank those involved in my investigation for their goodwill and generosity. I am humbled by the experiences shared by the service users who contributed to my report.

Peter Boshier
Chief Ombudsman

Acknowledgements

First, I would like to thank the people whose experiences I drew on to understand and illustrate how the system operates for those it is intended to support, and their families and whānau. I am extremely grateful for their willingness to share their experiences.

I would also like to thank the Ministry of Health—in particular, staff from the Disability Directorate—for their assistance and cooperation throughout this investigation.

I am also grateful to the Canterbury, Capital & Coast, Southern, Waikato and Waitematā District Health Boards and their staff. The information they provided was immensely valuable and I appreciate the time staff spent assisting my investigators during site visits.

My thanks also to the other individuals and organisations who contributed to this investigation, including the following.

- Careerforce
- Deputy Commissioner Disability (Health and Disability Commissioner)
- Disability Commissioner (Human Rights Commission)
- Disability Support Network
- District Inspectors
- Forensic Coordination Service (Intellectual Disability)
- HealthCare New Zealand (Explore Specialist Advice)
- Health Quality & Safety Commission
- IHC New Zealand
- Nursing Council of New Zealand
- People First New Zealand
- Providers of Regional Intellectual Disability Supervised Accommodation Services and Community Residential Support Services
- Te Pou

A note about terminology

Language around disability is important. I acknowledge that people have differing views on the meaning, accuracy, and effects of particular terms.

I have chosen to use the term **'intellectual disability'** in this report. People with an intellectual disability are a diverse group who may experience challenges understanding new or complex information, learning new skills or tasks, and living independently.

I acknowledge that some people in the disability community prefer the term 'learning disability' or 'learning impairment'. In Te Ao Māori, 'tangata whaikaha hinengaro' may be used to refer to a person with an intellectual or learning disability. The United Nations Convention on the Rights of Persons with Disabilities (which New Zealand has signed) refers to 'intellectual disability' as 'intellectual impairment'.

My use of the term intellectual disability is for consistency with the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act). This defines an intellectual disability as a permanent impairment that:

- results in an IQ of 70 or less;
- results in significant deficits in adaptive functioning in areas such as communication, self-care, home living, and social skills; and
- becomes apparent before a person reaches the age of 18.

I have generally used the term **'service users'** when referring to people who access disability-related services funded by the Ministry. Other terms are used on occasion for particular groups of service users.

See Appendix 1 for a glossary of other terms used in this report.

Executive summary

In late 2018, I became increasingly concerned about a continuing shortage of specialised hospital accommodation for people with an intellectual disability requiring secure care and rehabilitation, and about the conditions in which some of these people were being detained. I made further enquiries and was alerted to a range of problems with the operation of the High and Complex Framework (the Framework). This is a network of services to support people who are either subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) or who have specialised needs that cannot be managed in mainstream services.

The Ministry of Health – Manatū Hauora (the Ministry) is the steward and kaitiaki of the health and disability system. It is also directly responsible for planning and funding services under the Framework, which are delivered by District Health Boards (DHBs) and non-governmental organisations (NGOs).

The people supported under the Framework are few in number—between 200 and 250 at any given time. They are, however, people with complex support needs and, in most cases, have limited ability to advocate for themselves.

As a National Preventive Mechanism (NPM) under the United Nations Optional Protocol to the Convention Against Torture (OPCAT), I had previously identified concerns about the conditions of detained persons in a number of places of detention, including secure care facilities for people with an intellectual disability.[1] I was also aware of apparent breaches of the United Nations Convention on the Rights of Persons with Disabilities (Disability Convention) in relation to the conditions experienced by some people with particularly high and complex support needs.

On 22 January 2019, I therefore advised the Director-General of Health of my decision to commence a self-initiated investigation under section 13 of the Ombudsmen Act 1975 (Ombudsmen Act) into the administrative practices of the Ministry in relation to the facilities and services provided for people with an intellectual disability, particularly those who are subject to the Framework.[2] I advised that my investigation would incorporate case studies to illustrate how capacity and capability issues were affecting individuals with an intellectual disability living under the Framework. Further information was set out in the Terms of Reference.[3] My investigation was publicly announced on 14 February 2019.

My investigation involved obtaining and reviewing a range of written information from the Ministry and interviews with key Ministry staff. Information was also provided by DHBs, a small number of providers of community-level services and other key stakeholders. I also arranged for visits to each of the DHBs providing hospital-level secure care services for people with an intellectual disability, in order to meet with staff, service users, and their whānau or other support persons, and to observe the conditions in which service users live. I considered this was important in order to gain a real understanding of how any systemic issues impacted on the people that the Framework is designed to support.

1 My OPCAT role is to examine, and make any recommendations that I consider appropriate to improve, the treatment and conditions of detained persons in a number of places of detention, including secure care facilities for people with an intellectual disability.

2 As required by s 18(1) of the Ombudsmen Act 1975. This investigation has been conducted pursuant to ss 13(1) and 13(3) of that Act.

3 Investigation Terms of Reference.

In late 2020, I wrote to the Ministry seeking some further information and confirming that my investigation would focus on the stewardship role the Ministry performs, and the discharge of its obligations arising from that role during the period January 2015 to December 2020.[4]

I advised that I understood those obligations to include:

- ensuring the system is run effectively within the allocated funding, and in line with ministerial expectations (this would include taking all reasonable steps to find beds for service users subject to care orders within the available funding);
- identifying the need to increase capacity and capability where necessary, and with a view to the long-term sustainability of the system (this would include advising on ways to meet any shortfall in available beds for service users subject to the Framework); and
- providing free and frank advice to inform ministerial decisions.

The overarching role of the Ministry of Health is to improve, promote, and protect the health and wellbeing of New Zealanders through its leadership of the health and disability system.[5] The Ministry is the steward or kaitiaki of that system for the public interest. In the Ministry's own words, its stewardship role is to *'sustain, nurture, grow, and develop the system'*.[6] The Ministry is accountable for ensuring a whole-of-system view is adopted when deciding how best to provide facilities and services for people with an intellectual disability in New Zealand, and applying a long-term, proactive, collaborative approach to the care of the system. This involves treating the health and disability system as an asset that needs to be well managed and monitored to deliver effectively for the New Zealand public over time.

The Ministry has contracted various parties to perform functions and deliver services within the system, but has retained specific responsibilities relating to funding, planning and monitoring disability support services. This includes services for the small group of people who are subject to the Framework. As the steward of the health and disability system, and the funder and planner of disability support services, the Ministry of Health must take reasonable steps to ensure that the Framework is operating to uphold service users' rights and promote their quality of life.

During the course of my investigation, I found significant problems with the Framework and capacity pressures. These have worsened since I commenced my investigation in January 2019. The impacts of these problems have been significant. Court proceedings were deferred and people remanded back to prison due to the lack of an available bed in a hospital secure care facility. Service users whose needs related primarily to an intellectual disability were inappropriately accommodated in mental health units. Other service users were placed in facilities outside their home regions, away from family and whānau. Seclusion rooms and de-escalation areas in secure care facilities were used as bedrooms.

The Ministry took some actions in an effort to address the problems. It sought additional funding for Framework services in 2015–2016, supported the development of a small number of individualised service units at Capital & Coast DHB (due to open later this year), and in 2020 agreed to fund additional beds that have very recently become available at Waitematā DHB. However, I found that while the Ministry was clearly cognisant of the problems and the pressures, in my view its actions were not sufficiently urgent, targeted, or strategic to address these. I consider the

4 I note that some information relating to events prior to this period has been included where it provides relevant context.

5 Health Act 1956, s 3A.

6 Ministry of Health *Annual Report for the Year Ended 30 June 2020* (21 December 2020) at 4.

Ministry's response was not calibrated to reflect the extent to which it was required to fulfil its general stewardship accountabilities or meet the requirements of the IDCCR Act.[7] The Ministry needed to develop a clear roadmap in collaboration with service providers to address the capacity crisis and its associated problems, but omitted to do this.

I found that the Ministry did not have an overarching plan to guide decisions within the Ministry or development and delivery of Framework services. There was a lack of planning to address the capacity pressure in hospital-level services as this intensified, and then spread to community-level services. I do not consider that the actions the Ministry took to address the capacity issue and associated problems were timely or sufficient.

I also found that the Ministry's monitoring function has been focused on crisis management, rather than examining causes and identifying potential systems solutions to areas of Framework underperformance. In particular, the evidence I considered indicated that the Ministry did not adequately monitor and review:

- the progress of service users whose needs were not fully anticipated when the Framework was established;
- the effectiveness of operational processes around placement and transition; and
- service delivery issues, including the environment and workforce.

I found that the operational issues that I identified lacked a national perspective. The planning and monitoring strands of the Ministry's management processes needed to be more interconnected.

In addition, I consider the Ministry omitted to develop good quality and timely advice about Framework performance, and did not adequately highlight the urgency of the issues to the Director-General or to the responsible Minister.

It is clear that in late 2020 the Ministry recalibrated its response to the Framework capacity crisis, and it seems that the Ministry may now be taking more substantial steps towards responding to the ongoing crisis.

My opinion

In my opinion, the Ministry's administrative actions and decisions when discharging its responsibilities to provide facilities and services to people with an intellectual disability, as part of its stewardship of the New Zealand health and disability system, during the period of my investigation, were not adequate. I am not satisfied that the Ministry took all reasonable steps to ensure the Framework operated so as to maximise the opportunity for service users to live balanced, satisfying lives with the greatest possible level of independence. The Ministry's performance in this regard appears to be inconsistent with Disability Convention obligations to protect and promote the rights of persons with disabilities, and to prevent breaches of their rights.

My specific concerns, in the context of the Ministry's responsibilities as kaitiaki of the disability system, are summarised below. Taken together, they are the basis for my opinion that the Ministry has acted unreasonably.

7 See page 29 and Appendix 7 for further information about the IDCCR Act.

Planning

- The Ministry did not have or develop a cohesive, overarching plan to guide the effective delivery of Framework services and ensure that the rights of all Framework service users were upheld.
- The Ministry should have commenced collaborative planning with DHBs about the Framework at an earlier juncture.
- The Ministry did not develop a timely, targeted plan to mitigate the acute capacity crisis and ensure the statutory requirements of the IDCCR Act were able to be met.
- The Ministry did not adequately incorporate community-level services into planning for the Framework.
- The Ministry did not adequately include workforce issues in its ongoing Framework planning.

Actions taken

- The Ministry did not develop or implement adequate measures to address the acute capacity issue.
- The Ministry did not adequately support the ongoing needs of the Framework. For example, it did not:
  - adequately progress demand modelling;
  - proactively address the need for additional capacity in the Auckland region; or
  - take timely steps to ensure that regional hospital-level services were funded equitably.

Monitoring and reviewing

- The Ministry's systems for monitoring and reviewing the overall operation of the Framework were not adequate.
- The information collected by the Ministry about Framework performance did not enable a collective and comprehensive understanding of service delivery or operational issues. In particular:
  - there was no consistent reporting across the Framework concerning service delivery, processes or outcomes;
  - the data collected on seclusion and restraint did not enable the Ministry to track seclusion and restraint trends on an ongoing basis, or readily allow for the disaggregation of data about Framework service users; and
  - there was no process in place to measure unmet capacity demand.
- The Ministry did not have a system or process for reviewing information it collected about:
  - service delivery issues and outcomes for service users;
  - the care and rehabilitation of service users whose needs were not fully anticipated when the Framework was established;

- Framework operational processes, including service user placement, transition, and absconding incidents; and
- the use of seclusion and restraint in Framework services.

Advice provided

- The Director-General was not provided with good quality and timely advice about the Framework, including the immediate capacity issue and the longer-term challenges.
- The briefings provided to the Minister did not fully adhere to the 'no surprises' principle in terms of the frequency and significance of the issues.
- The Ministry's briefings and advice to the Minister did not fully convey the extent to which the Ministry was unable to deliver on its responsibilities and gave the impression that the longer-term solutions provided adequate mitigation.

Recommendations

Pursuant to section 22(3) of the Ombudsmen Act 1975, I recommend that the Ministry take the following steps to fulfil its stewardship obligations of the system:

1 The Ministry as a priority:

- a ensures that service users referred by the courts are accommodated in appropriate facilities;
- b develops a comprehensive strategic plan for the High and Complex Framework, in collaboration with DHBs and NGO providers, that:
  - i identifies short-, medium- and long-term goals and objectives;
  - ii clearly outlines roles and responsibilities;
  - iii ensures there are clear and transparent processes for Framework operations, including the interfaces between prison, hospital- and community-level services; and
  - iv defines intended outcomes in accordance with the Disability Convention.
- c monitors and reviews the new strategic plan;
- d ensures that contractual arrangements are up-to-date and consistent with the new strategic plan; and
- e reviews the processes for data collection, analysis and review about the use of seclusion and restraint in Framework services, bearing in mind Article 31 of the Disability Convention.

2 The Ministry ensures that:

- a providers of community-level services are complying with the security requirements as set out in the Secure Services Matrix; and
- b reporting on the Framework is consistent and structured, and enables the Ministry to:

i receive timely feedback on any service delivery and operational issues; and

ii monitor the progress of service users with intensive support needs, and of women and youth.

3 Additionally, the Ministry ensures that the Minister is kept regularly updated on any significant issues as they arise, and on progress to improve Framework performance.

4 The Ministry reports to me on the progress of these recommendations on a quarterly basis for 12 months following the first report, due on 24 September 2021, and subsequently at mutually agreed intervals.

Figure 1: Drawing.

Introduction

The Ministry of Health – Manatū Hauora (the Ministry) describes itself as kaitiaki of the health and disability system.[8] This role is explained by it as follows:[9]

> *The Ministry steers improvements that help New Zealanders live longer, healthier and more independent lives. This stewardship role is crucial for the system: it does not mean the Ministry delivers or controls everything, but rather it makes sure the system works well, at each stage, for every New Zealander.*

This means it is accountable for ensuring a whole-of-system view is adopted when deciding how best to provide facilities and services for people with an intellectual disability in New Zealand. This involves applying a long-term, proactive, collaborative approach to the care of the system in the public interest, including treating the health and disability system as an asset that needs to be well managed and monitored to deliver effectively for the New Zealand public over time.

Given its overarching statutory objective of improving the health of New Zealanders,[10] the Ministry has acknowledged the need to *'achieve more accessible, effective disability support services'*.[11]

8 Ministry of Health *Statement of Strategic Intentions 2017 to 2021* (20 October 2017) at 4.

9 Above n 8, at 10.

10 New Zealand Public Health and Disability Act 2000 (NZPHD Act), s 3(1)(a)(i).

11 Ministry of Health *Statement of Strategic Intentions 2017 to 2021*, above n 8, at 18.

Around 38,000 New Zealanders access disability support services funded by the Ministry.[12] Although the majority receive 'mainstream' services, there is a very small group of people who require more specialised support.[13] This group consists of:

- people who are subject to compulsory orders under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act);[14]
- people with mental health–related needs and an intellectual disability, who have not been charged with any criminal offending but are detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act);[15] and
- a 'civil population' of people with an intellectual disability who meet eligibility criteria for having high and complex needs, on the basis that their behaviour may pose serious risk of physical harm to themselves/others and their needs cannot be met by mainstream community services.[16] [17]

The needs of this group of people are met through a network of services, known as the High and Complex Framework (the Framework), which is funded and planned by the Ministry.[18] The Framework was developed by the Ministry in 1999 in anticipation of the IDCCR Act, which came into force in 2004. For the avoidance of doubt, decisions taken at that time about the structure of the Framework are beyond the scope of this investigation.

12 Ministry of Health *Demographic Report for Clients Allocated the Ministry of Health's Disability Support Services: 2018 update* (December 2019) at 10. Services for people over the age of 65 are generally funded by District Health Boards (DHBs). The Ministry continues to fund services for its disabled service users after they turn 65, until they are assessed as requiring aged residential care, at which time the DHBs take over funding responsibility.

13 Mainstream disability support services include home-based support, community residential support, day services, equipment and modifications, and respite care.

14 Further information about the IDCCR Act is set out at page 29 and in Appendix 7.

15 The majority of these people were placed under the Mental Health Act prior to the introduction of the IDCCR Act.

16 This group access Framework services on a voluntary basis. It includes people who have an ongoing need for Framework services following the cancellation or expiry of a compulsory care order.

17 Of the 200–250 service users supported under the Framework at any given time, approximately half will be under the IDCCR Act. For example, in December 2020, there were 104 people subject to compulsory care orders under the IDCCR Act, 81 civil clients, 9 people subject to orders under the Mental Health Act, and 9 others.

18 Section 3(1) of the NZPHD Act provides for the public funding and provision of personal health services, public health services, and disability support services.

Between 200 and 250 people are supported under the Framework at any given time. Figure 2, Figure 3 and Figure 4 below show the breakdown by gender, ethnicity, and age. As at 31 December 2020, there were 203 Framework service users.

Figure 2

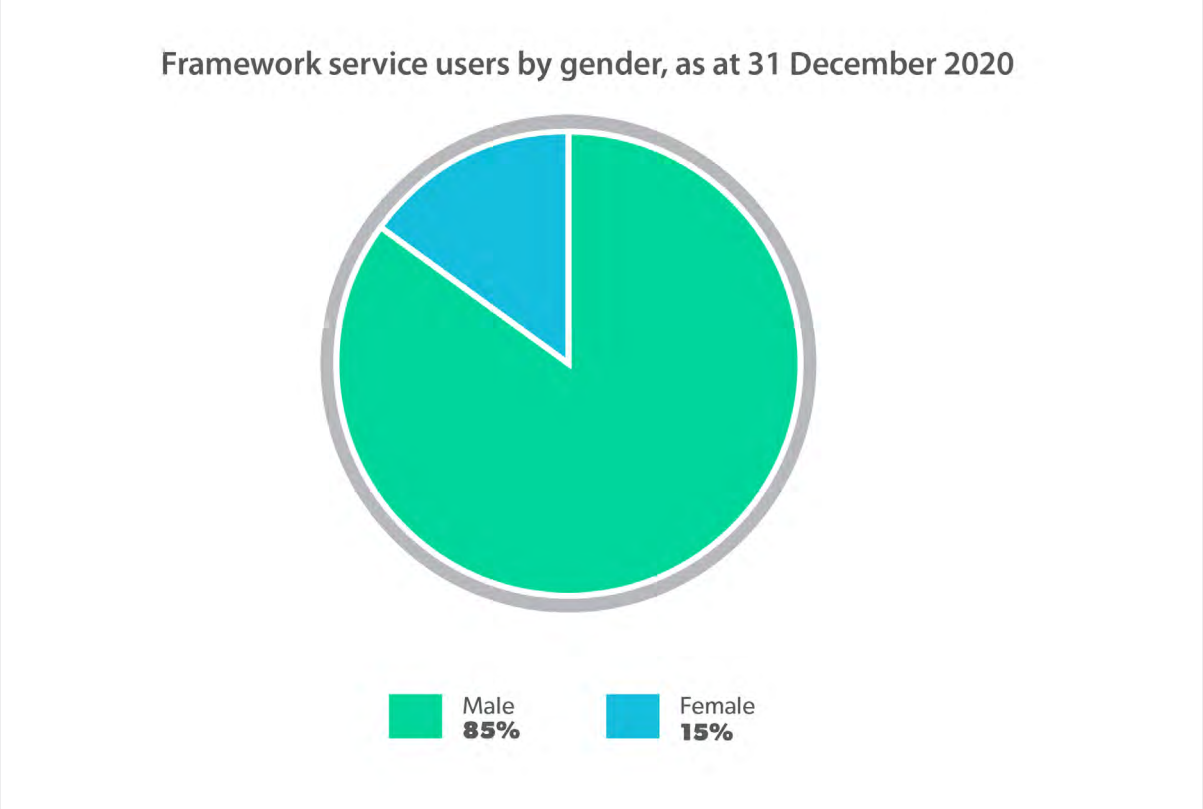


Figure 3

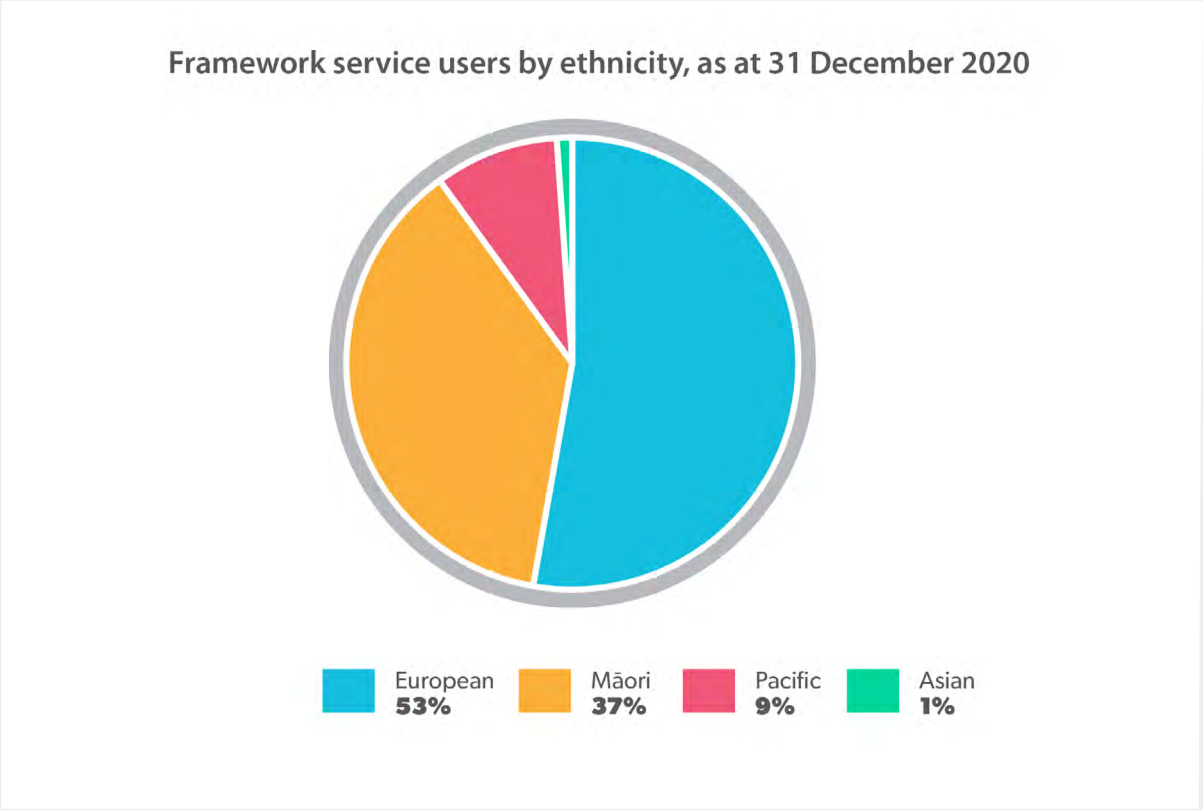
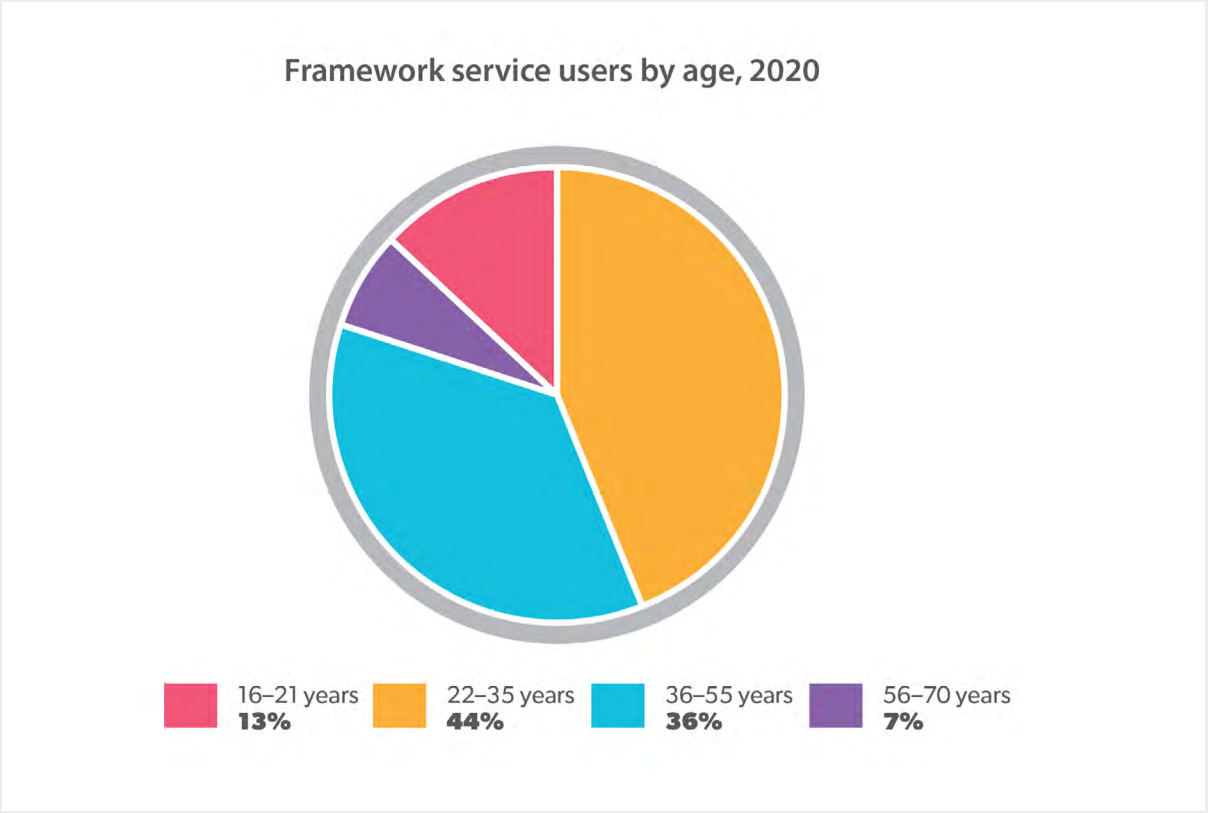


Figure 4


Framework service users by age, 2020
16–21 years
13%
22–35 years
44%
36–55 years
36%
56–70 years
7%

High and Complex Framework services

By contractual arrangement between the Ministry and the DHB and non-governmental organisation (NGO) providers, people supported under the Framework receive assessment, care and rehabilitation services. These include:

- accommodation and associated services in secure hospitals, known as Regional/National Intellectual Disability Secure Services (RIDSS/NIDSS), provided by DHBs;[19]
- accommodation and associated services in community-level secure or supervised facilities, known as Residential Intellectual Disability Supported Accommodation Services (RIDSAS), provided by NGOs;
- the services of Community Liaison Teams, who provide specialist consultation and liaison services to Framework service users in community-level facilities; and
- other rehabilitative and vocational programmes provided by NGOs.

Of the 200 to 250 people supported under the Framework, around 60 to 70 are accommodated in hospital-level secure care units.[20]

Five DHBs hold contracts for the provision of regional hospital-level secure services: Canterbury, Capital & Coast, Southern, Waikato and Waitematā. These services are delivered through the provision of specifically designated 'beds', located in dedicated forensic intellectual disability units, or in forensic mental health units. There are currently around 66 beds contracted for hospital-level secure care across the five DHBs.

Residential services for people who are subject to community court orders, and for civil service users not subject to a compulsory care order, are provided by seven NGO disability providers holding contracts for the provision of secure and supervised community-level accommodation services. These providers are: Te Roopu Taurima, IDEA Services, Emerge Aotearoa Ltd, Community Living Ltd, NZCare Group Ltd (trading as Navigate), Community Care Trust and PACT Group. The Ministry purchases around 200 community-level beds, with services provided in homes shared by no more than six people.

Figure 5 below shows the distribution of Framework residential services across the country.

19 See Appendix 8 for further information about the regional and national hospital-level secure services.

20 Also known as forensic inpatient units. In this context, 'forensic' refers to a secure inpatient setting for people whose health and disability needs intersect with offending behaviours.

Framework residential service providers

Secure Hospitals

Waitematā, Waikato, Capital & Coast, Canterbury and Southern

Community-level secure or supervised facilities

- Te Roopu Taurima
- IDEA Services
- Emerge Aotearoa Ltd
- Community Living Ltd
- NZCare Group Ltd (trading as Navigate)
- Community Care Trust
- PACT Group

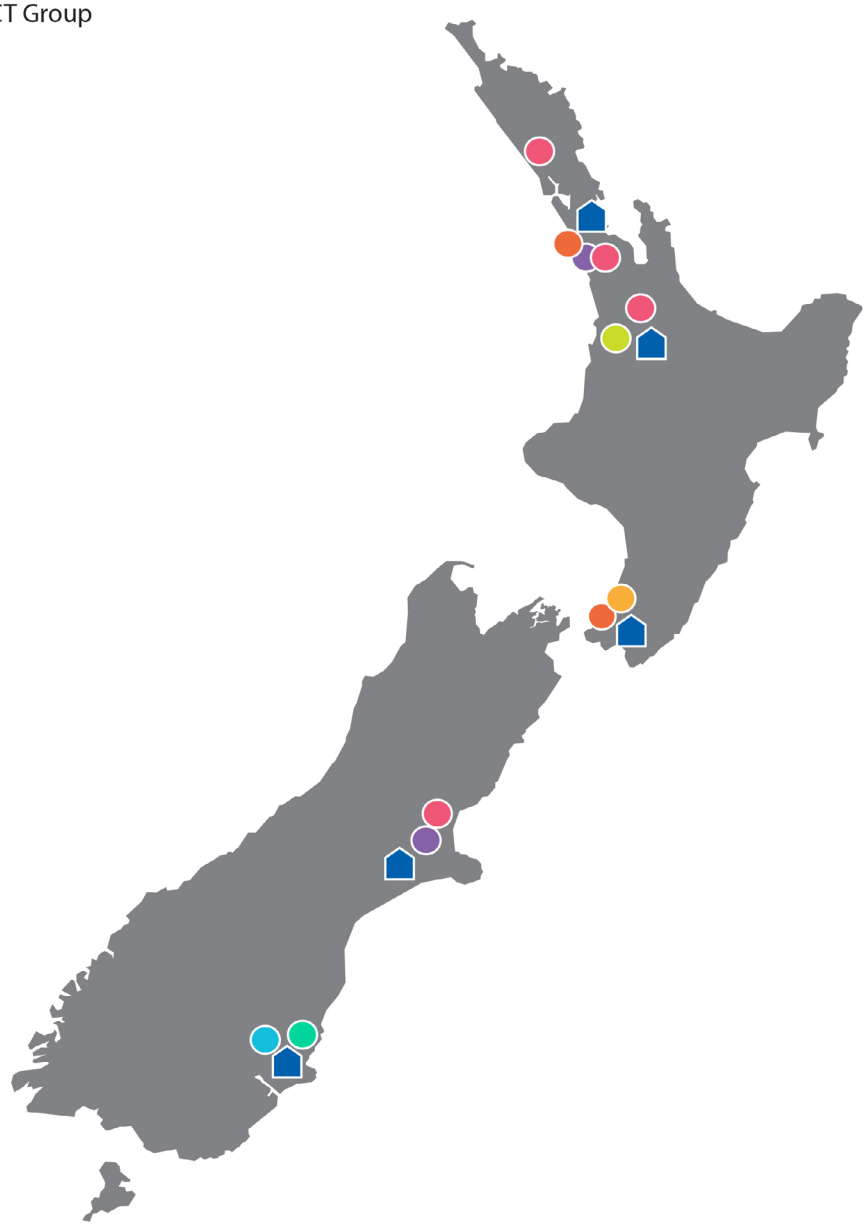


Figure 5: Framework residential service providers.

The Framework is intended to provide an approach that helps maximise personal autonomy and choice without jeopardising health and safety. The ultimate goal is for those supported under the Framework to live a balanced and satisfying life without offending, and to have the greatest possible level of independence. Guidance developed by the Ministry states (emphasis added):[21]

> *…Any provision of care and rehabilitation used under this framework must place a **central focus on promoting the quality of life** of [service users]. This is not only because it is necessary from a human-rights perspective but also because this approach is more likely to produce more long-term positive change.*

In late 2018, I became concerned about a perceived lack of capacity in hospital-level secure care units to accommodate people under the Framework. I was also aware that there were disabled people with intensive support needs who had been in hospital for considerable periods of time with significant restrictions on their movement and quality of life. Depriving people of their liberty raises a number of human rights concerns.[22] As the steward of the public interest in the New Zealand health and disability system, the Ministry of Health must take reasonable steps to ensure that the Framework comprises policies, processes, and systems that are fit for purpose and operate effectively for people in New Zealand, upholding the rights and promoting the quality of life of its service users. In addition, the Ministry has specific responsibilities as the planner and funder of disability support services. Accordingly, in late 2018, I advised the Director-General of Health of my intention to investigate.

My investigation

On 22 January 2019, I notified the Director-General of Health of my decision to commence a self-initiated investigation under section 13 of the Ombudsmen Act 1975 (Ombudsmen Act) into the administrative practices of the Ministry in relation to the facilities and services provided for people with an intellectual disability, particularly those who are subject to the Framework.[23] I advised that my investigation would incorporate case studies to illustrate how capacity and capability issues were affecting individuals with an intellectual disability supported under the Framework. Further information was set out in the Terms of Reference.[24] My investigation was publicly announced on 14 February 2019.

My investigation has included the following:

- obtaining and reviewing a range of written information from the Ministry, and interviews with relevant Ministry staff;
- obtaining from the Ministry information about a number of service users who had been brought to my attention during the scoping and early investigative phases, and whose experiences appeared to illustrate, at a very personal level, the matters I intended to examine;

21 Ministry of Health *A Guidance Document: Care and Rehabilitation under the High and Complex Framework* (unpublished, May 2016) at 25.

22 Catalina Devandas-Aguilar *Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities* (A/HRC/40/54) 11 January 2019 at 4–6. See also comments made by New Zealand's Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities in its report *Making Disability Rights Real Whakatūturu Ngā Tika Hauātanga: 2014–2019* (June 2020) at 17, 82–87, and 94–97.

23 As required by s 18(1) of the Ombudsmen Act 1975. This investigation has been conducted pursuant to ss 13(1) and 13(3) of that Act.

24 Investigation Terms of Reference.

- visiting each of the five DHBs providing hospital-level secure services and two providers of community-level services, to observe the facilities and service users' living conditions and to interview key staff and service users and, in some cases, their families/whānau;
- obtaining and reviewing written records from the DHBs;
- obtaining and reviewing information from a range of other agencies, organisations and individuals, either in writing or through meetings or interviews;
- reviewing a range of relevant publicly available information; and
- reviewing international conventions, relevant legislation, and case law.

Further information about my investigation methodology is contained in Appendix 2.

In late 2020, I wrote to the Ministry seeking some further information and confirming that my investigation would focus on the stewardship role the Ministry performs, and the discharge of its obligations arising from that role during the period January 2015 to December 2020. I advised that I understood those obligations to include:

- ensuring the system is run effectively within the allocated funding, and in line with ministerial expectations (this would include taking all reasonable steps to find beds for service users subject to care orders within the available funding);
- identifying the need to increase capacity and capability where necessary, and with a view to the long-term sustainability of the system (this would include advising on ways to meet any shortfall in available beds for service users subject to the Framework); and
- providing free and frank advice to inform ministerial decisions.

Relevant evidence and my findings on these matters are set out in Part 3: Framework performance: the role of the Ministry as system steward.

On 22 April 2021, I invited the Ministry to comment on my provisional opinion and proposed recommendations. On 29 April 2021, I invited a number of third party stakeholders to comment on relevant sections of my provisional opinion. I have considered all responses and reviewed and revised my opinion where necessary.

My report

My report which sets out the basis for my opinion has four parts:

- Part 1: Background to the Framework sets out the background to the Framework. It includes a brief overview of the health and disability system, the legislative framework, and the roles and responsibilities of key players.
- Part 2: Status of the Framework describes the status of the Framework during the period I investigated.
- Part 3: Framework performance: the role of the Ministry as system steward describes and discusses the Ministry's stewardship of the Framework.
- Part 4: My opinion sets out my opinion and recommendations.

As noted above, I have considered the experiences of a number of service users and their families/whānau, who agreed that I could refer to their situations to illustrate how challenges facing the Framework are affecting them. The Ministry was informed that I intended to speak to these service users as part of my investigation. DHB and NGO service providers facilitated arrangements for my staff to meet with them and their whānau or other support persons. My staff consulted again with these service users and their whānau after I had prepared my provisional opinion. This report contains sensitive personal information about some of the service users interviewed for my investigation. They include male and female service users who range in age from their early 20s to early 60s, and are of European, Māori, and Pacific ethnicities. I have changed their names to protect their identities and omitted other identifying details.

Figure 6: Photograph of entrance corridor at Henry Rongomau Bennett Centre.

Part 1: Background to the Framework

New Zealand's health and disability services are delivered by a complex network of people and organisations, as shown in Figure 7 below. It is a mixed system, with services provided by public and private entities (for-profit and not-for-profit). It is also, in broad terms, a 'semi-devolved' rather than 'centralised' system.

The Ministry has an overall accountability for leading the health and disability system. Much of the day-to-day business of the health system is undertaken by DHBs. They plan, manage, provide, and purchase health services for the people in their areas, implement government health and disability policy, and work to ensure the effective and efficient delivery of services.

The complexity of the health and disability system can be challenging. It was noted in the briefing provided to the incoming Minister of Health in December 2020 that the system is complex, with a high degree of devolved decision making, and that organisations do not always collaborate around the needs of individuals and communities.[25] The briefing also noted the *'overlap in the functions of organisations and lack of clarity on mandates which leads to duplication of effort, inefficiency and reduced accountability for performance'*, observed by the Health and Disability System Review.[26]

25 Ministry of Health *Briefing to the Incoming Minister: Part A: The New Zealand Health and Disability System* (December 2020) at 12.

26 New Zealand Health and Disability System Review – Hauora Manaaki ki Aotearoa Whānui *Interim Report: Pūrongo mō Tēnei Wā* (August 2019) at 64, as cited in Ministry of Health Briefing to the Incoming Minister: Part A: The New Zealand Health and Disability System, above n 25, at 12.

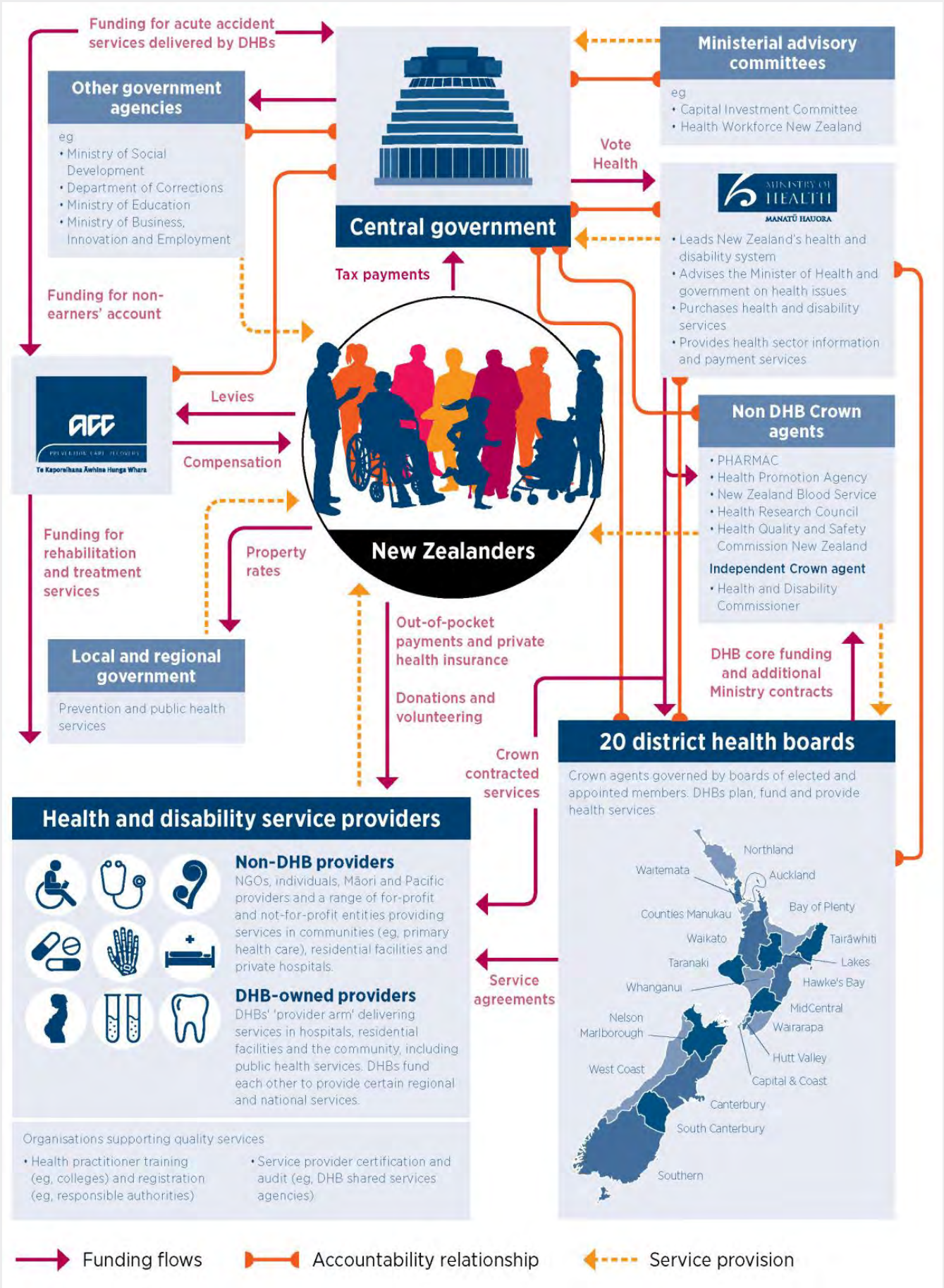


Figure 7: Overview of the New Zealand health and disability system (source: Ministry of Health Annual Report 2019).

In order to assess the Ministry's role in overseeing the Framework, it has been necessary for me to carefully examine the key legislative provisions and the consequent roles and responsibilities of the various parties involved.

Legal framework

New Zealand is a signatory to the following two international conventions.[27]

United Nations Convention on the Rights of Persons with Disabilities (Disability Convention)

The Disability Convention is an international human rights treaty designed to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.[28]

In addition to the General Obligations set out in Article 4 of the Disability Convention, the following articles are of particular relevance to this investigation:

- Article 12 – Equal recognition before the law
- Article 14 – Liberty and security of person
- Article 15 – Freedom from torture or cruel, inhuman or degrading treatment or punishment
- Article 17 – Protecting the integrity of the person
- Article 25 – Health
- Article 26 – Habilitation and rehabilitation
- Article 31 – Statistics and data collection

See Appendix 3 for relevant details.

United Nations Convention on the Rights of Children (UNCROC)

UNCROC enshrines fundamental children's rights into international law.[29] New Zealand ratified the Convention in April 1993, but maintains reservations with respect to some of the Articles.

Article 37(c), which relates to the rights of children deprived of liberty, is particularly relevant to the Framework.[30] It provides that *'every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so'*. New Zealand has reserved the right not to apply Article 37(c) in circumstances where *'the shortage of suitable facilities makes the mixing of juveniles*

27 An international convention or treaty is an agreement between different countries, which is legally binding to the contracting States. A convention becomes legally binding to a particular State when that State ratifies it.

28 United Nations Convention on the Rights of Persons with Disabilities (Disability Convention) 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008). New Zealand ratified the Disability Convention in full on 26 September 2008, and the Optional Protocol to the Disability Convention on 4 October 2016. The Optional Protocol establishes an individual complaints mechanism.

29 United Nations Convention on the Rights of the Child (UNCROC) 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990).

30 Under the IDCCR Act and the Criminal Procedure (Mentally Impaired Persons) Act 2003, children and young people with an intellectual disability who engage in offending can be directed to hospital-level secure services.

and adults unavoidable; and further reserves the right not to apply [the Article] where the interests of other juveniles in an establishment require the removal of a particular juvenile offender or where mixing is considered to be of benefit to the persons concerned'.[31]

I note also:

- Article 20, which requires the State to provide *'special protection and assistance'* to children not living in their family environment; and
- Article 23, which relates to children with a disability and states that a disabled child *'should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'*.

See Appendix 4 for relevant details.

Domestic law

There is a range of legislation relevant to both the state sector generally and to the health and disability system more specifically, including:

- the State Sector Act 1988;
- the Public Service Act 2020;
- the Health Act 1956;
- the New Zealand Public Health and Disability Act 2000; and
- the Crown Entities Act 2004.

Some information about these legislative instruments can be found in Appendix 5. Given the focus of my investigation on the Ministry's stewardship accountabilities, I note the following, with reference to the State Sector Act 1988 and the Public Service Act 2020.

State Sector Act 1988 and Public Service Act 2020

For most of the period I have looked at,[32] the general responsibilities of the public service, including the Ministry, were as set out in the State Sector Act 1988.[33] On 7 August 2020, this was replaced by the Public Service Act 2020.[34]

Under section 32(1) of the State Sector Act, the Chief Executive was responsible to the appropriate Minister for a range of matters, including:

- *'the stewardship of the department or departmental agency, including of its medium- and long-term sustainability, organisational health, capability, and capacity to offer free and frank advice to successive governments';*
- *'the stewardship of … assets and liabilities on behalf of the Crown that are used by or relate to (as applicable) the department or departmental agency; and … the legislation administered by the department or departmental agency'; and*

31 Ministry of Justice "UN Convention on the Rights of the Child" (August 2020) Constitutional Issues and Human Rights.

32 January 2015 to December 2020.

33 State Sector Act 1988.

34 Public Service Act 2020.

- *'the efficient and economical delivery of the goods or services provided by the department or departmental agency and how effectively those goods or services contribute to the intended outcomes'.*

Similar stewardship obligations are contained in the Public Service Act.[35] This contains new purposes and five public service principles, including the provision of free and frank advice to Ministers and the proactive promotion of public service stewardship. The latter includes stewardship of long-term capability and people, and public service systems, processes, and assets. The Public Service Act confirms that the fundamental character of the public service is acting with a spirit of service to the community. Te Kawa Mataaho Public Service Commission (which replaced the State Sector Commission) states that the Public Service Act aims to provide a more unified or 'joined-up' public service that focuses on the benefit to individuals, organisations, and communities.[36]

Chief Executives remain responsible to the appropriate Minister for the operation of their agency, supporting their Minister to act as a good steward of the public interest, giving advice to Ministers (including on the long-term implication of policies), and the efficient delivery of goods and services provided by the department and how effectively those contribute to intended outcomes.[37] Chief Executives are required to uphold public service principles and preserve, protect, and nurture the spirit of community service amongst their employees.[38]

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and Criminal Procedure (Mentally Impaired Persons) Act 2003

On 1 September 2004, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) and Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act) came into force.[39] The two Acts work together:

- the IDCCR Act provides for the compulsory care and rehabilitation of individuals with an intellectual disability who have been either found unfit to stand trial on, or convicted of, an imprisonable offence and then ordered into care; and
- these orders are generally made by a criminal court as a disposition under the CP(MIP) Act.

The purposes of the IDCCR Act are:[40]

> *(a) to provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence; and*
>
> *(b) to recognise and safeguard the special rights of individuals subject to this Act; and*
>
> *(c) to provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.*

35 Public Service Act 2020, s 12(1).

36 Te Kawa Mataaho Public Service Commission *Public Service Act 2020 Factsheet 2* (11 August 2020).

37 Public Service Act 2020, s 52.

38 Public Service Act 2020, ss 12–13.

39 It has not been necessary for the purposes of this investigation to examine the extent to which this legislation is consistent with international law. However, I note that in 2014 the United Committee on the Rights of Persons with Disabilities raised concerns that New Zealand's criminal justice system did not recognise that a disabled person should only be deprived of liberty when found guilty of a crime. See Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of New Zealand (2014)* at [21]–[22] and [29]–[34].

40 IDCCR Act, s 3.

The IDCCR Act explicitly states that a person is defined as having an intellectual disability if they have a permanent impairment that:[41]

- results in an IQ of 70 or less;
- results in significant deficits in adaptive functioning in areas such as communication, self-care, home living, and social skills; and
- becomes apparent before a person reaches the age of 18.

As summarised in Figure 8 below, there are two parts to the process by which a person may become subject to an order under the IDCCR Act and placed in a hospital or community facility. First, there is a determination as to whether the person is fit to stand trial. The second step (predicated on the above criteria for intellectual disability being met and the person being either found responsible if unable to stand trial due to mental impairment, or convicted) involves inquiries to assess the person's intellectual disability, followed by a final court hearing where a compulsory care order may be made.

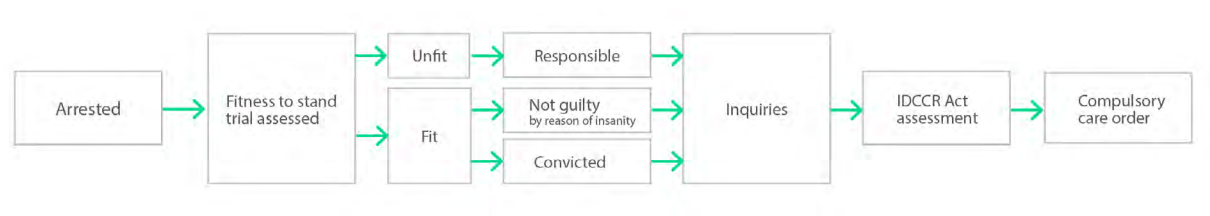


Figure 8: Operation of the CP(MIP) Act and IDCCR Act.

Further information about the IDCCR Act and a more detailed diagram of the process are set out in Appendix 7.

Roles and responsibilities

I have set out below my understanding of the roles and responsibilities of the various parties involved in the operation of the Framework: the relevant Ministers, the Ministry, Forensic Coordination Service (Intellectual Disability), DHBs, and community providers.

Minister of Health and Minister for Disability Issues

The Minister of Health, on behalf of the Government, is primarily responsible for the direction of, and priorities within, the health and disability system. The Minister is responsible for determining and promoting policy, and takes the lead in obtaining additional funding for health and disability support services through the budget process. The Minister is not generally involved in the day-to-day operations of the Ministry, including the operation and performance of the Framework.

The Minister for Disability Issues is responsible for advocating for the rights of disabled people across all government portfolios. In particular, the Minister must determine a strategy for disability support services to provide the framework for the Government's overall direction of the disability sector in improving disability support services.[42]

41 Refer to Appendix 7 for the full text of IDCCR Act, s 7.

42 NZPHD Act, s 8(2). Further information about this strategy can be found in Appendix 6.

It is important to note that an Ombudsman has no jurisdiction under the Ombudsmen Act over the decisions and actions of Ministers. However, an Ombudsman may investigate recommendations made to Ministers by public sector agencies, including the Ministry of Health.

Ministry of Health

The role of the Ministry is to improve, promote and protect the health and wellbeing of New Zealanders through its leadership of the health and disability system. In its most recent annual report, the Ministry acknowledged this as kaitiaki responsibilities, stating as follows:[43]

> *As kaitiaki of the health and disability system, we have the role and responsibility of stewards to sustain, nurture, grow and develop the system.*
>
> - *Sustain: We understand the strengths in the current environment and how to keep them going.*
> - *Nurture: We identify the vulnerable areas that require more specific help and ensure that help is provided.*
> - *Grow: We manage and provide for innovation to address rising demand and expectations for high-quality service.*
> - *Develop: We understand and provide for the long-term future of the health environment.*
>
> *As kaitiaki, we provide free and frank advice about effective interventions. We fund an array of national services (including disability support services and public health services) and provide clinical and sector leadership. We legislate and regulate, enforce, measure, monitor and evaluate as well as providing ongoing reviews of evidence about effective interventions. We set expectations and accountability requirements, fund national services and ensure that we meet New Zealand's international health and disability obligations.*
>
> *We bring together the policies to improve, protect and promote the health of New Zealanders and to increase health equity. Our responsibilities traverse the whole lifespan of health and wellbeing – from maternity and childhood, through to palliative care and old age – and includes disability.*

I acknowledge that the Ministry is also required to follow and implement the policy direction set by the Minister and the government of day, and to operate within its allocated funding.

Responsibilities in relation to the Framework

As steward of the health and disability system, the Ministry is accountable for ensuring the effective operation and performance of the Framework. The Ministry's role is one of leadership. The Ministry must, through its acts, decisions, and recommendations, maintain effective oversight of all the component parts of the Framework, and take reasonable proactive steps to ensure that the Framework is able to operate effectively.

Although the Ministry does not deliver Framework services, nor own the facilities or employ the workforce, it purchases the services and has primary accountability for Framework service performance. It must also monitor the ability of the system to deliver on intended outcomes. These include the provision of appropriate care and rehabilitation for those referred by the courts, and for those who have specific needs related to their age, gender, and culture, as well as their particular

43 Ministry of Health *Annual Report for the Year Ended 30 June 2020*, above n 6, at 4.

disability and risk profile. Areas requiring improvement need to be identified and solutions planned, in collaboration with DHBs, NGO providers, and other stakeholders. The Ministry has a key role in mapping the need for future capital investment based on demand modelling, and supporting the DHBs' business case process.[44]

Contractual relationship with DHBs

The contractual relationship between the Ministry and DHBs for hospital-level secure Framework services arises from the Crown Funding Agreement and its Service Coverage Schedule(s). These enable the Minister of Health to explicitly agree to the level of service coverage for which the Ministry and DHBs are held accountable. It confirms that it is the role of the Ministry to plan the type and quantity of services needed to deliver the Framework, and also confirms the need for the Ministry and DHBs to work together where there are gaps.

The Service Coverage Schedule for 2020/21 states (emphasis added):[45]

> *Responsibility for service coverage is spread across DHBs and the Ministry and lies with the party responsible for establishing service mix.* ***Where funding responsibility for services has not been devolved to DHBs, the Ministry is accountable for making service-mix decisions, and for ensuring delivery of service coverage, in collaboration with DHBs.***
>
> *DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high needs groups. This responsibility applies whether services are funded directly by the DHBs or by the Ministry.*
>
> *Gaps in service coverage can be related to issues of either funding or service delivery or both.* ***The Ministry and DHBs should work together to ensure resolution of service coverage gaps.***
>
> *It is the responsibility of funders to decide if additional levels or standards are, or can be funded or provided from the available funding.*

The Service Coverage Schedule defines service mix as the specific quantity and type of services that are used to meet the service coverage. At the most basic practical level, the level of service coverage should be sufficient to cover people referred by the courts.

Ministry business units involved in supporting the Framework

Within the Ministry, specific responsibilities are held by around 12 different directorates and business units, including the Disability Directorate.[46] Led by the Deputy Director-General Disability, the Disability Directorate is responsible and accountable for planning and providing

44 DHBs own their facilities and take the lead in developing business cases for building projects. Although the Ministry may be involved in supporting a DHB's business case proposal, it does not control the process. If a project requires capital investment of over $10 million, DHBs must obtain approval from the Capital Investment Committee. This is an advisory committee appointed under s 11 of the NZPHD Act. It provides advice to the Ministers of Health and Finance and to the Ministry on capital investment and infrastructure in the public health sector.

45 Ministry of Health *Service Coverage Schedule 2020/21* (October 2020) at 1.

46 Other relevant directorates include the DHB Performance, Support and Infrastructure Directorate, and Health Workforce. See Appendix 9 for a summary of the Ministry's role in relation to workforce.

policy advice to the Minister on issues related to disability and disability support.[47] It also has primary responsibility for commissioning disability support services, including Framework services.[48] Commissioning includes analysing relevant data to plan the service model, deciding what to purchase in order to achieve policy objectives, and monitoring, evaluating and making improvements where necessary. The Disability Directorate is required to maintain a view of capacity and capability, and to identify and report any need for more resource.

Within the Disability Directorate, it is the role of portfolio managers to manage approximately 700 contracts with providers of residential support.[49] One portfolio manager is tasked with managing all contracts for Framework services. Another key position within the Ministry is the Chief Advisor Disability and Director IDCCR Act (Chief Advisor IDCCR), who is responsible for oversight of the statutory processes under the IDCCR Act.[50] In effect, the Chief Advisor IDCCR has the key leadership role in relation to the Framework, with the portfolio manager primarily focused on administrative matters and relationships with the providers of Framework services.[51]

Forensic Coordination Service (Intellectual Disability)

The Ministry has contracted an agency known as the Forensic Coordination Service (Intellectual Disability) (FCS(ID)) to undertake specialist needs assessments and service coordination on its behalf. FCS(ID) is responsible for key operational aspects of the Framework, including the entry, oversight, and exit of eligible service users across the country. As such, the placement of service users within both DHB and NGO facilities is the responsibility of FCS(ID) on behalf of the Ministry.

FCS(ID)'s responsibilities are set out through a contracting arrangement known as the Streamlined Contracting Framework, which includes an overarching Outcome Agreement and Service Specifications.[52] Together these set out the Ministry's expectations in relation to a range of matters, including what the service will entail (its 'components'), service quality, and how the Ministry will monitor and audit performance. The Service Specification for FCS(ID) states that its key function is *'to work closely with services to ensure a seamless pathway for the service user beginning with referrals and co-ordinating effective needs assessment and service provision…'*. There is a resolution pathway to the Ministry for any **serious** unresolved issues with providers.

FCS(ID) is required to report to the Ministry quarterly on a range of matters, including:

- the delivery of its service to Framework service providers;
- whether services being delivered are meeting the needs of service users;
- gaps in services available from providers;

47 The Disability Directorate was established in October 2018. It took on responsibility for many of the functions previously carried out by Disability Support Services.

48 A report by the Productivity Commission defined commissioning as *'a set of inter-related tasks that need to be undertaken to turn policy objectives into effective social services'*. New Zealand Productivity Commission Te Kōmihana Whai Hua o Aotearoa *More effective social services* (August 2015) at xi.

49 Portfolio managers were previously known as 'contract relationship managers'.

50 The Chief Advisor Disability and Director IDCCR Act reports to the Deputy Director-General Disability, who in turn reports to the Director-General of Health.

51 Other roles with specific responsibilities relating to the planning, funding, and development of Framework services include the Group Manager, Operations and Managers, Northern and Central Operations. Prior to the establishment of the Disability Directorate, other roles with relevant responsibilities included: Director, Service Commissioning; Group Manager, Disability Support Services; Manager, Community Living Team; and Development Manager.

52 Further information about the Streamlined Contracting Framework and the Service Specifications for FCS(ID) are available on the Ministry's website.

- unresolved issues, problems, or complaints, and significant risks with service delivery by contracted providers;[53] and
- discretionary funding expenditure.

FCS(ID) employs a number of compulsory care coordinators. This is a statutory role—a compulsory care coordinator must be appointed for all care recipients.[54] In general terms, the coordinator's role is to oversee and manage the pathway for all service users referred by the courts, prisons, or forensic services as proposed care recipients.

The contract for FCS(ID) is held by Capital & Coast DHB.[55]

District Health Boards

Twenty DHBs are responsible for implementing the Government's health policies and for providing and funding a range of health and disability services in their districts. As Crown agents, DHBs are accountable to the Government through the Minister of Health.

Where DHBs provide services that are contracted and funded by the Ministry, including Framework services, they are directly accountable for specific performance measures concerning the quality of the service and outcomes.

As with FCS(ID), DHBs' responsibilities as providers of Framework services are set out through the Streamlined Contracting Framework, which includes an overarching Outcome Agreement and Service Specifications.[56] The DHBs are required to report to the Ministry on a range of performance measures on a six-monthly basis.[57] There are additional reporting requirements in some circumstances, such as for critical incidents.[58]

The current Service Specification for hospital-level secure services was developed in 2004. It identified that people requiring a high security environment and/or medium- to long-term placements would go to the national services provided by Capital & Coast DHB and Waitematā DHB. The other three DHBs would deliver services for people during the assessment phases of court proceedings. (In practice, the Waikato, Canterbury and Southern DHBs have been providing medium- to long-term secure care placements since their respective secure services were established.)

The Service Specification states that the DHBs are expected to accept all eligible FCS(ID) referrals where legal authority for entry exists. Where there is insufficient capacity, DHBs are expected to work with FCS(ID) to find a solution. Each DHB must prioritise their region, but is also required to accept inter-regional transfers if a bed is available.

53 Major risks or complaints must be reported within 24 hours.

54 The IDCCR Act, s 140 provides for the appointment of compulsory care coordinators by the Director-General of Health. Intensive service coordinators are appointed to oversee Framework services users who are not subject to the IDCCR Act.

55 FCS(ID) came into existence on 1 January 2013, after Capital & Coast DHB was awarded the contract from the Ministry of Health. From 2013 to 2018, FCS(ID) was known as the National Intellectual Disability Care Agency (NIDCA). Prior to 2013, there were five Regional Intellectual Disability Care Agencies (RIDCAs).

56 Service Specification for providers of hospital-level secure services.

57 Performance measures include, for example, the percentage of people with plans completed and reviewed within required timeframes, the number or percentage of people demonstrating improvements in skills/independence, the number or percentage of people demonstrating improved access to external support (family, whānau, advocates), and the number or percentage of people who transition out of the service.

58 A critical incident is defined in the Ministry's critical incident reporting form as any sudden and/or unusual event that could: be life threatening for the client or others; be dangerous, with the client at risk of grave harm; have significant consequences like the client being involved in criminal activity, absconding, or requiring emergency services or hospitalisation; or be a serious crisis that may result in media or political attention.

The Ministry's current contracts with all five DHBs came into effect on 1 July 2016 and expire on 30 June 2021. There have been contract variations during this time to provide for increases in the purchase price of the contracted services, and additional beds for specific service users.

DHBs also employ care managers. This is another statutory role. Care managers are appointed by compulsory care coordinators, and are responsible for overseeing the delivery of a care recipient's day-to-day care and support.

Community providers

As outlined earlier, the Ministry contracts seven NGOs to provide secure and supervised residential services for Framework service users who are able to be supported in community-based facilities.

Again, their responsibilities are set out through the Streamlined Contracting Framework, including the overarching Outcome Agreement and relevant Service Specifications.[59] These set out a number of objectives, such as that the provider:

- encourages and supports service users to increase their independence and self-reliance; and
- supports service users to attain and maintain maximum independence, full physical, mental, social, and vocational ability, and full inclusion and participation in all aspects of life.

As with the DHBs, community providers are required to report to the Ministry on a range of performance measures on a six-monthly basis, with additional reporting required in some circumstances, such as for critical incidents.[60]

Community providers also employ care managers, who are responsible for overseeing the delivery of day-to-day care and support provided to their service users.

59 Service Specification for providers of community-level services.

60 Performance measures include, for example, the percentage of personal plans completed within three months of entry and reviewed every 12 months, levels of staff turnover, service user involvement in their communities, levels of staff training, and the involvement of service users identifying as Māori with their whānau, hapū, or iwi. See n 58 for the definition of a critical incident.

Figure 9: Snoozelen sensory room at Pōhutukawa Unit.

Part 2: Status of the Framework

As outlined above, the Ministry's stewardship accountabilities extend to planning for and monitoring the performance of the Framework. In this part of my report, I set out relevant contextual information regarding the status of the Framework during the period I looked at and the challenges arising, which informed my view of the Ministry's actions ad decisions. This includes, in particular:

- the emergence of the capacity issue;
- a brief summary of reasons for the increased demand;
- the 'suboptimal workarounds' to address capacity issues; and
- other consequences and challenges for services users and providers.

Escalating capacity pressure

International research suggests that a bed occupancy rate of 85 percent supports patient flow, quality care, and cost-effective delivery.[61] Many hospitals in New Zealand run well above that figure.[62] Hospital-level secure services for people with an intellectual disability routinely operate at *'maximum'* contracted occupancy. However, the ongoing need to 'cap' admissions to some units and the co-location of other services meant that in real terms capacity was less than the number of contracted beds. Consequently, actual demand during the period I looked at often exceeded real capacity. In general, this has meant that there was no room to admit additional people referred by the courts, without another person exiting.

This situation is not one that appeared suddenly or without warning. I have been provided with a range of evidence that clearly showed the escalating capacity pressure throughout the 2015–2020 period, and that the Ministry was regularly and repeatedly informed about this.[63] I note the following by way of example:

- In 2013, it was evident that demand for hospital-level secure service beds was increasing. FCS(ID) noted in that year's third quarterly report to the Ministry: *'Areas highlighted in this quarter include the two issues carried from the last quarter, being the bed pressures in both Northern and Central regions, which have escalated…'.*[64]
- By 2015, there were clear signs of considerable strain and the need for careful planning needed to avoid the situation becoming acute. FCS(ID) noted in that year's first quarterly report to the Ministry that all North Island regions were under *'significant bed pressure'.*
- In 2016, the National Manager of FCS(ID), in consultation with the Ministry, commissioned a review of the people receiving hospital-level secure care at that time. The purpose was to look at any factors that might be impeding the transition of service users to lower levels of hospital care such as step-down services[65] (where available) or to a community-level service. This was *'in response to the increasing pressure that is being placed on the restricted number of [hospital-level secure] beds available nationally and hence the need to ensure optimal service delivery within available resources'.* The review report summary noted:[66]

  > *The harsh reality is that unless there is significant increase in capacity the [hospital-level secure] services will soon be in the untenable position of not having the capacity to accommodate individuals made care recipients by [the courts] and who require hospital secure care without transitioning a potentially risky individual to a less secure facility.*

- In early 2017, FCS(ID) advised the Ministry that bed pressures had reached a critical point, with no beds available in hospital-level secure services on most days. Reports from then through to the third quarter of 2020 referred to this pressure, including a 2017 report that stated:[67]

61 Health and Disability System Review, above n 26, at 181.

62 Health and Disability System Review, above n 26, at 181.

63 Including evidence from the DHBs, FCS(ID) and the Ministry.

64 As noted previously, between 2013 and 2018, FCS(ID) was the Regional Intellectual Disability Coordination Agency (RIDCA).

65 For the purposes of this report, 'step-down services' are DHB facilities providing beds and associated services designed to assist service users transitioning from the hospital level secure care into the community. The different types of services are described in Appendix 8.

66 *NIDCA Review of RIDSS Clients for Transition Planning* (unpublished, 2016) at 21.

67 *National Intellectual Disability Care Agency Quarterly Report to Ministry of Health* (unpublished, 20 April 2017) at 13.

> *The High and Complex ID sector is now considered to be in a crisis. There is no longer capacity to meet the demand and mitigation actions requiring sub-optimal work arounds are being negotiated on a weekly basis. As and when these occur they are being highlighted to the MoH Contract Relationship Manager and the Chief Advisor DSS (also the Director IDCC&R).*

- In early July 2018, Ministry staff advised the Director-General of Health that the courts had recently been advised that the Framework was unable to accept the referral of a person for a court-referred assessment. It was noted that this was the first time this had happened since the IDCCR Act was operationalised in 2004.
- In 2018's third quarterly report to the Ministry, FCS(ID) stated: *'This matter has worsened since the last quarter and the [Framework] is now inoperable in most [North Island hospital-level secure services] with daily monitoring and reporting [to the Ministry] by FCS…'*.[68]
- In August 2019, FCS(ID) advised the Ministry that issues with the providers of community-level services needed to be *'discussed and elevated with some urgency'*.[69]
- In September 2020, FCS(ID) notified the Ministry that the issues related to Framework capacity had reached a critical tipping point, resulting in *'a lack of operational capacity and actualised infrastructural service failure'*.[70] FCS(ID) advised that the Framework was compromised nationally, with capacity issues in hospital and community-level services.
- In late 2020, FCS(ID) reiterated that capacity pressure had expanded to community-level services. The third quarter 2020 FCS(ID) report stated that access to secure beds and transition planning was being impeded by *'extreme pressure'* on staffing and capability in community-level services. There were also concerns about compliance with the Secure Service Matrix following multiple absconding incidents.[71] The report for hospital-level secure services remained acute.

FCS(ID) quarterly reports are a key means by which the Ministry is informed about activity relating to the Framework, including incidents, complaints, provider issues, regional issues, and other matters.[72] The quarterly reports include a risk register, which shows identified risks and assigns a risk rating based on impact and likelihood.

I note that the inability to provide for court-ordered assessments and secure care recipients was an identified risk in 2013 reporting and onwards. Figure 10 below shows the FCS(ID) quarterly reports' risk register ratings from 2013 to 2020. In the first quarter of 2013, the consequence was 'substantial', the likelihood 'almost certain', and the overall risk or 'uncertainty' rating was 'medium'. By the first quarter of 2015, the consequence had moved to 'extreme', and the overall risk rating was 'high'. Since the first quarter of 2017, the likelihood has been recorded as 'occurring', and the overall risk rating 'extreme'.

68 *National Intellectual Disability Care Agency Quarterly Report to Ministry of Health* (unpublished, 29 October 2018) at 13.

69 Email from the FCS(ID) to the Ministry of Health regarding bed capacity pressures by region (16 August 2019).

70 Email from the FCS(ID) to the Ministry of Health regarding ongoing regional bed capacity issues (9 September 2020).

71 The Secure Services Matrix is part of the Ministry's contract with providers. It sets out the procedural, relational and environmental security requirements for each type of service. The Secure Services Matrix requires community-level secure facilities to have locked doors but not to be 'escape-proof'. The security is more reliant on staffing and relationships than in hospital-level secure facilities.

72 See pages 70 to 74 for other mechanisms through which the Ministry receives information about the quality of Framework services.

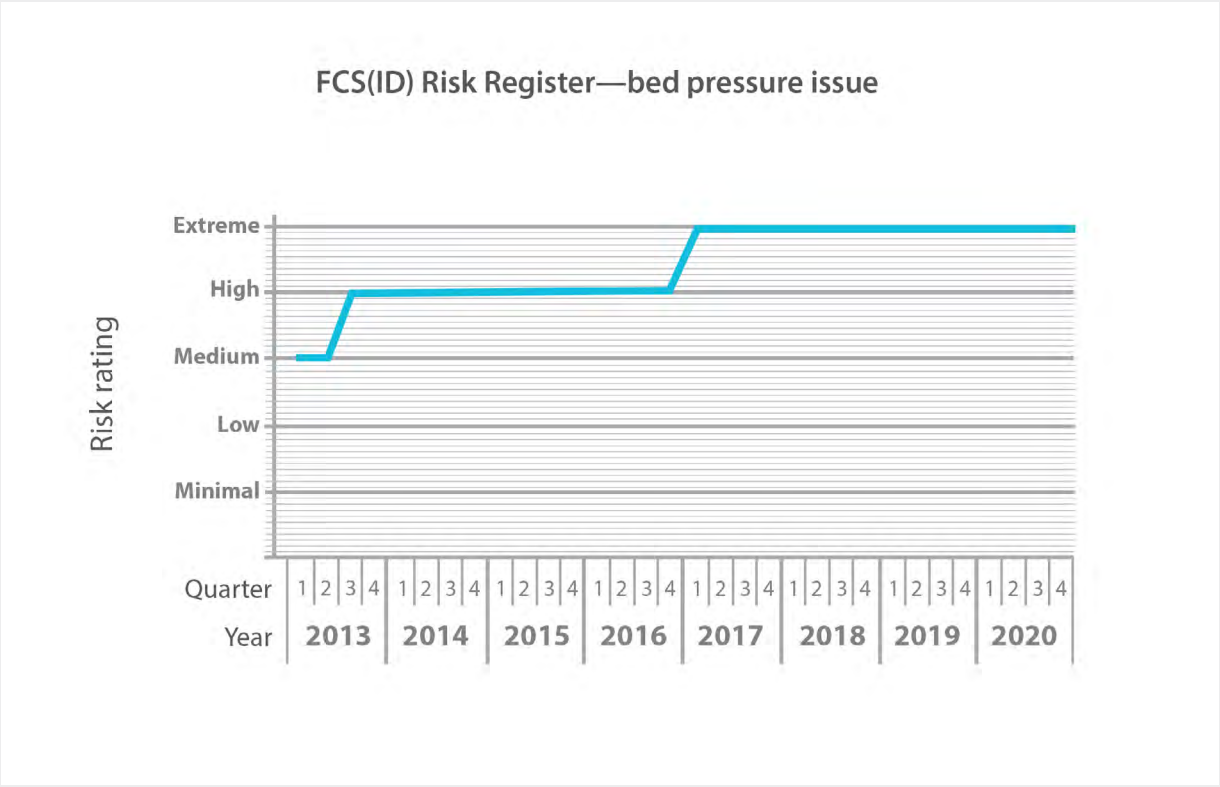


Figure 10: FCS(ID) Risk Register—bed pressure issue

I note also that in May 2017, senior staff from the five DHBs providing hospital-level secure services under the Framework wrote to the Ministry raising serious concerns about under-resourcing in that sector. They stated:[73]

> *We believe statutory obligations under the IDCCR Act are not being met nationally, and the population intended to benefit from this legislation are being so poorly served that we are now at a crisis point.*

In relation to capacity, the DHBs stated:

> *The failure to ensure adequate capacity within the sector is such that there is now a serious and in some areas imminent risk of harm to those individuals unable to access appropriate care, as well as to service providers and their staff who are attempting to provide care in existing services and the community.*

They also referred to a perceived decline in the capability of community residential services, which was making community transition more difficult. The DHBs emphasised the importance of regional solutions to the capacity issues, and noted concerns about the effects of moving service users away from their family and support networks.

The Ministry responded to the DHBs in July 2017, acknowledging there had been significant bed pressure over the previous two years, and that there was a need for more flexible and adaptable hospital-level options over and above the additional step-down beds that had been funded in recent years. The Ministry advised that it was:

73 Letter from Waitematā DHB, Waikato DHB, Capital & Coast DHB, Canterbury DHB and Southern DHB to the Ministry of Health regarding critical under-resourcing in Regional Intellectual Disability Secure Care (unpublished, 5 May 2017).

- considering a proposal for individualised units for high-risk mental health and disability service users, which would provide care and rehabilitation to people who are highly vulnerable and who have complex and differing needs from the usual short- to medium-term population; and
- in the early stages of developing a long-term strategy for the Framework, which would consider what was needed for the future support of people under the IDCCR Act. It would involve detailing the pressures currently being experienced by the sector, and the short- and longer-term goals for the development and rationalisation of beds contracted from the DHBs. The Ministry advised it anticipated completing this work by the end of November 2017.[74]

Causes of increased demand

I understand that the root causes of the capacity issues are multifaceted and vary according to region. Information provided by the Ministry, FCS(ID) and the DHBs identifies the following, in particular.

- The nature and size of the cohort requiring secure care had, to some extent, changed from that anticipated when the IDCCR Act was enacted in 2004. There was a larger-than-expected group of young offenders with mild to moderate intellectual disabilities and complex needs relating to issues such as drug and alcohol dependency, and abuse and neglect during their early years.[75] An increasing number of these young offenders became subject to the IDCCR Act sometimes, it appears, due to a lack of alternative options and/or a lowering of the threshold for fitness to plead.[76] Many had not previously accessed disability services and did not identify as intellectually disabled.
- There was a small but accumulating cohort of people with extremely complex needs who required a high level of long-term if not lifelong support, and/or highly individualised supports.[77] Some were exhibiting a higher level of offending and/or complex behaviours, making it less likely that they could be accommodated in community-based facilities.
- The physical layout of some facilities meant not all contracted beds could be made available where, for example, a service user's needs were such that they were unable to share living space.
- In some areas, notably Auckland and the Midlands region, there was significant population growth with no corresponding increase in service provision.
- Some regions and facilities had significant workforce challenges, including difficulties recruiting staff with appropriate training and experience, and extended staff absences due to work-related incidents and injuries.

74 Further detail about the outcome of the work is detailed in Part 3: Framework performance: the role of the Ministry as system steward of this report. In short, it appears that work on the long-term strategy was not completed.

75 The information provided to me does not quantify the actual size of the cohort relative to the expected size.

76 In other words, people who would previously have been found fit to plead are now more likely to be found unfit to plead.

77 Records indicate that throughout my investigation period, this was estimated to comprise 4–8 people. The information provided to me suggests that, depending on the criteria, this cohort is currently at the upper end of this range.

- Several regions were at different times affected by decreased capacity and capability in community services. This put pressure on the hospital services, as community providers sought admission for service users they were no longer able to support, and there were limited opportunities to transition those who no longer required hospital-level care.
- Increasing volume pressure in forensic mental health, as described by the Mental Health Commissioner in his report of 2020, meant a decline in the ability of those services to help with capacity issues in forensic intellectual disability services.[78]

The relatively small size of the Framework population—just 200–250 of the 38,000 people using disability services—meant that a relatively small increase in the number of those requiring support had a significant effect.

Therapeutic environments

To provide context and appreciate the consequences of the capacity crisis, I considered it necessary to understand the importance of therapeutic environments for this group of service users. There are some guidelines for mental health inpatient units in New Zealand, but there appeared to be no specific requirements for forensic intellectual disability facilities. DHB and Ministry staff advised that a therapeutic environment is a highly specialised environment that facilitates the effective delivery of care and rehabilitation and so maximises the potential for people to live good lives, without offending and with as much independence as possible. This requires two key elements:

- well-designed facilities that support the overlapping clinical, operational, and secure aspects of Framework services; and
- a skilled and experienced workforce supported by effective systems, delivering a consistent model of care.

It has been noted in various reviews and reports, and in the recent assessments by the Ministry of all DHB forensic facilities, that although much of the hospital infrastructure in New Zealand would benefit from improvement, DHB secure care facilities for people with intellectual disabilities, in particular, do not readily enable staff to deliver good quality care.[79] It was also a consistent view held by all DHB staff interviewed for my investigation.

Further details about the individual facilities and their limitations are included in Appendix 10. It is reported that, to a varying degree, none of the facilities are fit for purpose and some have physical limitations that create safety risks. They lack the environmental flexibility and specialisation necessary for the myriad support needs Framework service users have. The limited availability of designated therapeutic areas within some units, the co-location of service users with significantly different support needs, and the use of mental health units make it more difficult for staff to provide individualised care.[80]

78 Office of the Health and Disability Commissioner *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner* (June 2020) at 111–112.

79 See page 60 for comment on the Ministry's recent Clinical Facilities Fit for Purpose (CFFFP) assessments.

80 In some cases, mental health units were used because the specialist intellectual disability facility was unsuitable for a particular service user (for example, it does not have the necessary level of security). In the case of Waikato DHB, there is no specialist facility for intellectual disability. In other cases, service users were placed in mental health units pending the availability of a bed in the intellectual disability unit.

In terms of the second element, staff from all five DHBs providing hospital-level secure services confirmed that they have struggled to recruit experienced nurses and psychologists especially, and overseas recruitment is often necessary. They also advised that there are limited qualification opportunities and training for staff in intellectual disability care. This has made it difficult for some DHBs to provide the specialist care needed to meet the individual needs of all service users. Further information about the Ministry's role in addressing workforce issues is contained in Appendix 9.

Several DHBs also reported difficulties in maintaining a balanced roster of experienced nurses and support workers. They noted that the use of casual staff made it more difficult to provide continuity of care, that many service users find staff changes disruptive to their routine, and that inexperienced staff were less confident in intervening to prevent incidents from escalating. They commented further that inexperienced or casual staff often become fearful for their personal safety and restrict their interactions with service users to the minimum.

Bryan

Bryan, aged in his forties, has lived in a hospital-level secure service for over a decade. For the last four years, Bryan has resided in a separate area at one end of the unit. He requires the support of two staff at all times. A family member described Bryan as a very social person who *'likes routine'*. Bryan enjoys watching Mr Bean and Tomb Raider.

Before he moved into his own area, Bryan had a bedroom within the main part of the unit. He was frequently involved in behavioural incidents, including assaults, on staff and other service users. A District Inspector's report noted that other service users targeted Bryan, which *'caused him a great deal of anxiety'*.[81] These encounters led to Bryan being restrained and secluded. A staff member said that *'[Bryan] was being re-traumatised consistently, because staff were having to intervene'*.

In response to the ongoing concerns, the DHB created the separate space, comprising several rooms, solely for Bryan's use.

While this has consequently reduced the unit's overall bed capacity, DHB staff said that now that Bryan is able to spend time in his own environment and have more control over when he interacts with other service users, there has been a significant drop in assaults and staff injuries, as well as a reduction in ongoing trauma to Bryan.

'Suboptimal workarounds'

As a result of the capacity issues outlined above, it became increasingly difficult over the period looked at for this investigation for FCS(ID) to find available beds. In its reports to the Ministry, FCS(ID) referred to a number of *'suboptimal workarounds'* to address capacity issues, and some of these are described below.

81 A District Inspector is a lawyer appointed by the Director-General of Health under both the Mental Health Act and the IDCCR Act who provides an *'independent monitoring function to ensure that people subject to the [Acts] have their legal rights respected and upheld'.*

Court proceedings deferred

Evidence showed that on a number of occasions during the period I looked at, FCS(ID) had to seek the deferral of a person's legal proceedings until such time as a bed became available in a suitable facility.[82] Where the court agreed to a deferral, the person was remanded back to prison until there was an available bed.[83] This occurred for the first time in July 2018 but has since occurred on more than ten occasions.

Additional time in prison due to a lack of an available bed in a suitable facility is unsatisfactory for the individuals concerned. The prison environment can be a distressing and wholly inappropriate environment for people with a significant intellectual disability and other needs related to their mental health, or autism, for example. In some cases, proceedings were deferred for as long as six weeks. Deferrals also mean additional hearings must be scheduled, putting further pressure on the courts.

Records show that some Ministry staff considered this to be a failure by the Ministry to meet its responsibility to ensure all individuals subject to the provisions of the IDCCR Act are provided with an appropriate residential placement.

Assessment in prison

Under the IDCCR Act and the CP(MIP) Act, assessments should not occur in a prison as, for the purposes of those acts, a prison is not considered a secure facility.[84] However, I found evidence during the course of my investigation of one case where a person was assessed in prison in breach of the IDCCR Act.

Zeb

Capacity pressures in the Framework meant that Zeb, aged in his twenties, spent additional time in prison awaiting legal assessment.

Zeb had been referred to FCS(ID) for possible disposition under the IDCCR Act. With no suitable hospital-level secure care beds available, FCS(ID) advised the Ministry that Zeb would be assessed in prison in order to avoid any further delays. Proceedings had already been deferred once, and FCS(ID) saw no prospect of a hospital bed becoming available in time for the assessment to be completed within the 30-day statutory timeframe. With no hospital bed available and placement in a community-level service considered unsuitable due to the risk of Zeb absconding, the specialist assessment was completed in prison.

82 This could be proceedings where it was anticipated that the court would make an order for inquiries (to determine fitness to plead or the most suitable method of dealing with a person found unfit to stand trial), or an order making the person a care recipient or special care recipient to be detained in a secure facility. Deferral requests were initially made by compulsory care coordinators. In late 2018 and at the request of FCS(ID), the Ministry assumed responsibility for submitting letters to the court explaining the reason for the deferral request. Such letters typically explain that should secure care be required and a community option opposed:

[Placement] within a hospital level secure placement will be unavailable at this time as all Ministry of Health funded beds within the DHBs intellectual disability services are full and the Ministry is not in a position to offer a suitable alternative at this time … The Ministry in consultation with the FCS therefore respectfully request that [Mr/Ms X's] matters set down for [x date] be adjourned for a period of [x days/weeks], to enable us to work with the FCS and our DHB colleagues to create a placement…

83 In some cases, the person may be remanded to a community facility or to their designated bail address in the community.

84 IDCCR Act, ss 9(2) and 9(4), and CP(MIP) Act, ss 4, 23(2)(b), and 35(2).

I also found evidence of other cases where people were held in prison but taken out for the day for an assessment and then returned to prison. Records from FCS(ID) indicate this occurred on at least 24 occasions between January 2017 and July 2020. I understand there is some debate over the legality of this practice, and the issue remains under active consideration by the Ministry. What is clear, however, is that the assessment itself should not take place in prison.

Placements out of region

On several occasions, FCS(ID) had to arrange for a person to be accommodated out of region and not in the facility nearest to the place they call home. Out-of-region placements make it more difficult at a practical level for family and whānau to visit regularly. This is important in and of itself, and to allow for family and whānau involvement in a service user's recovery and/or transition to a less restrictive environment. For some people, being far from home also creates a physical dislocation that may adversely affect their emotional and/or spiritual wellbeing.

Viliami and Zeb

Viliami was urgently admitted to an out-of-region hospital-level secure service after a breakdown in his community placement. The reason for this out-of-region placement was because the secure service at the DHB in Viliami's home region was at capacity. Following conflict with other service users, Viliami moved into his own area within the secure service facility.

At around the same time, Zeb was detained in prison undergoing his own legal proceedings. FCS(ID) wrote to the Court and explained that, should Zeb need to be assessed (for the purposes of the IDCCR Act), there were no appropriate beds available. FCS(ID) requested that the Court defer Zeb's proceedings until appropriate accommodation could be arranged. Matters were adjourned, and Zeb was remanded to prison.

At the next hearing, FCS(ID) again informed the Court that hospital facilities were at capacity. The DHB in Zeb's home region was unable to admit him, partly because it was supporting Viliami. Zeb's specialist assessment was conducted in prison, contrary to law.[85]

When the Ministry subsequently advised the Court that there was still no suitable placement for Zeb, the Court granted a short period in which to make arrangements.

Ministry staff then met with staff from the two relevant DHBs to discuss Viliami's transfer to his home region. It was agreed that the DHB in Viliami's home region would admit Zeb, whose support needs were not as high as Viliami's. The intention was that two service users would be swapped once the DHB in Viliami's home region was in a position to admit him.

On that basis, Zeb was made a care recipient and transferred out of his region, into the care of that second DHB.

Viliami continued to occupy his own area at the first DHB's facility. He was supported to socialise in the main lounge area with his peers and spend time outside. A senior DHB staff member said that staff did some '*amazing things*', as Viliami was '*out in the courtyard having a shave, having a massage and a haircut*'. However, there were also multiple incidents and altercations. Staff said that Viliami:

> *… was being detained and he was unhappy and he didn't like it, and of course we didn't have access to anything else to help with that. It was a long way for his family to come.*

Approximately six months after their admissions, Viliami and Zeb were transferred to the secure services in their respective home regions. Following the swap, Viliami was accommodated in a mental health unit for just over two months, before being transferred to the intellectual disability unit.

When my investigation team met with Viliami, he expressed a wish to return to a home in the community and spend more time with family.

Zeb advised that he liked the food where he was and was happy with his room, but unhappy that he couldn't smoke. He enjoyed playing on the ward's Xbox and PlayStation.

85 See n 84.

Use of beds in forensic mental health units

To mitigate the bed shortage, in some cases, the Ministry was able to purchase additional beds from forensic mental health units. I understand this was done on a 'supernumerary' basis. In other words, it involved the Ministry paying for a bed for a particular service user at a higher rate until that person was able to be discharged or transferred to one of the contracted beds. However, records show that in the course of the period I looked at between 2015 and 2020, the Ministry's ability to purchase these 'supernumerary' beds declined significantly as pressure on forensic mental health beds increased and facilities started experiencing 100 percent occupancy rates.[86]

In addition, during the course of my investigation I found evidence indicating that Framework service users in some regions were placed in mental health units because they could not be safely supported in the intellectual disability facilities. This was the case at Canterbury DHB, where the AT&R Unit does not have the required level of security for some service users. From 2017, female Framework service users at Waitematā DHB were accommodated in a forensic mental health unit rather than in the Pōhutukawa Unit.

In interviews, DHB staff also expressed concerns about the appropriateness of supporting people whose needs relate primarily to their intellectual disability together with mental health service users under the care of staff with experience in mental health but not necessarily in intellectual disability, and to some extent at least, in line with a mental health model of care.[87]

86 Office of the Health and Disability Commissioner *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*, above n 78, at 111–112.

87 While the Framework service users in mental health units may be under the care of the intellectual disability service clinical team or clinician, their day-to-day care and support is largely delivered by unit staff.

Eddy

Issues arose after FCS(ID) was unable to locate an appropriate placement for Eddy. Aged in his thirties, Eddy has lived all over New Zealand.

In early May 2018, FCS(ID) was made aware that Eddy would soon require access to a hospital-level secure service bed for IDCCR Act assessment. As Eddy was imprisoned at the time, the request went first to the nearest secure service. The DHB providing that service advised both FCS(ID) and the Ministry that it could not safely manage Eddy, given the mix of service users it had at that time.

In mid-May 2018, the Ministry and FCS(ID) arranged for Eddy to be placed under the care of another DHB. While in that DHB's facility, Eddy caused extensive structural damage to the ward and was involved in regular behavioural incidents. That DHB requested that FCS(ID) move Eddy to another facility as soon as possible. Matters were escalated to the Ministry, which advised it was liaising with the first DHB to find a solution.

After a serious incident, Eddy was taken into police custody and remanded in prison. Ministry staff said a number of placement options were explored for Eddy, but there were no available hospital-level beds. The Ministry advised the first DHB that Eddy would likely transfer there after he came under the IDCCR Act. That DHB reiterated its concerns around its ability to manage Eddy's risk.

In mid-2018, Eddy became a special care recipient[88] and was directed to the first DHB. As staff there did not consider that Eddy could be safely managed in its inpatient intellectual disability service, he was placed in a mental health unit. Initially, Eddy spent time in a seclusion bedroom; however, he later moved into the main part of the unit.

Eddy presented as a well-groomed young man who spoke articulately. He told my investigation team that he likes to *'hang out'* with other service users, and enjoys spending time exercising outside. DHB staff advised that Eddy is very capable at learning and planning.

88 A special care recipient is person who, due to the very serious nature of their offence, is subject to a longer compulsory care order and liable to (or serving) a term of imprisonment.

Use of de-escalation areas and seclusion rooms

There are a number of service users who have lived in de-escalation and seclusion areas for lengthy periods of time (see for example, the stories of Jasper, page 51 and Adam, page 66).

De-escalation areas and seclusion rooms have specific purposes. They are designed as short-term solutions for people who are highly agitated and who require an environment with particular features until a calmer state ensues. They may be used for a person who has been referred for assessment, when the presence of an intellectual disability has not yet been established and when admission straight into the main part of a unit would be unsafe or otherwise inappropriate.

Seclusion rooms are typically sparse, with bare walls and a single mattress. Windows provide a source of natural light. Service users may have access to en-suite bathroom facilities, or, alternatively, rely on staff to make nearby toilets available.

Using seclusion areas as substitute bedrooms and living spaces is not appropriate for the person placed there, or for staff and other service users who may require those spaces to manage high-risk situations. In my view, it would also be inconsistent with New Zealand's obligations under Article 15 of the Disability Convention.[89]

Louis

Louis is aged in his thirties. With the exception of two short stays in community homes, Louis has lived in a hospital-level secure service since his late teenage years.

It is acknowledged that environmental stressors have impacted upon on Louis' behaviour and care.[90] Louis is particularly sensitive to noise. He has spent lengthy periods in seclusion or in his bedroom, away from the stimulus present in the general ward.

Over the course of around one-and-a-half years, Louis spent much of his time in seclusion. He was involved in frequent behavioural incidents. When possible, staff supported Louis to exit seclusion and access quieter areas in the general ward. The DHB supporting Louis noted that seclusion was only used when clinically indicated, and that a seclusion room was not used as an alternative to a bedroom. Although Louis' family visited him regularly, he had limited social contact with others.

Louis gradually started spending less time in seclusion as he increased his ability to independently manage situations he found challenging. In the general ward, Louis spent much of his time in his bedroom. DHB staff expressed the opinion that Louis had experienced trauma as a result of the extended period he spent in seclusion. In addition, Louis' family commented that his prolonged time in seclusion appeared to have had an impact on his overall capabilities.

When my staff met with him, Louis said that he had been at the DHB a *'long long long time'*. His goal was to live in his own flat in the community. Louis' family said that they appreciate the ongoing commitment and dedication of DHB staff in trying to do the best for Louis.

89 See Appendix 3.

90 As shown in Louis' clinical records.

Other consequences and challenges

There are a number of other consequences and challenges within Framework services, including the following.

Framework eligibility restricted

In September 2018, FCS(ID) advised the Ministry that due to the critical shortage of beds for people under the Framework, it was no longer able to accept civil referrals from mainstream Needs Assessment and Service Coordination Services.[91] FCS(ID) advised that this decision simply *'reflects the pressure the forensic services are under nationally and the need to prioritise those with statutory mandate'*.[92] The restriction continued for the remainder of the period that was the subject of my investigation. The impact of this was that mainstream services were having to support people with higher and more complex needs, without necessarily being equipped to do so.

Sector relations

Ministry staff commented during my investigation that the capacity pressure tended to make relationships with providers more difficult. There was a clear tension between the contractual obligations of DHB providers, in particular, to accept service users into Ministry-funded beds, and the autonomy of DHBs to admit and discharge service users.

The records I reviewed showed clearly that DHBs were reluctant to accept referrals in circumstances where they did not consider that they could provide safe, appropriate care. Where DHBs advised FCS(ID) and the Ministry that they could not accept a new admission when, on paper, there was an unoccupied bed, the Ministry's initial response was to reiterate its expectations that the contracted beds be provided. Similar issues arose in the course of FCS(ID)'s and the Ministry's engagement with community-level providers.

Aside from Waikato, all of the DHBs at some point capped the number of beds they were able to offer, having determined that they were unable to safely support service users to the number provided for in their contracts. Factors relevant to such a decision typically included service user acuity and mix, staffing issues, and limitations relating to the physical environment.

It is clear from the evidence I have seen that, at times, relationships between the DHBs, FCS(ID) and the Ministry were difficult. All parties were clearly frustrated. The Ministry expected to be able to rely on the availability of the beds it purchased. FCS(ID) had day-to-day responsibility for coordinating placements, and it was generally their staff (care co-ordinators)[93] who had to front up to the courts when there were no beds available. DHBs considered the Ministry's position reflected a failure to appreciate the realities of their circumstances.[94] Some DHB staff stated that what made this worse was that it was a crisis that had been years in the making and had been clearly signalled. In their view, the Ministry's efforts to address it were consistently too little, too late.

91 FCS(ID) advised that it would continue to provide full Needs Assessment and Service Coordination Service liaison and advice, and fully engage in any transition from or to the Framework.

92 Email from National Manager FCS(ID) to Ministry regarding FCS(ID) ability to accept civil referrals (unpublished, 13 September 2018).

93 Care coordinators have a statutory responsibility to place Framework service users in designated facilities.

94 This is reflected in a range of contemporaneous correspondence provided by the Ministry, FCS(ID), and the DHB, and in information provided by staff during interview.

Service users with specialised needs

During my investigation, it became evident that the more specialised needs of some service users were not fully planned for when the Framework was established. This includes a small group whose intensive support needs cannot be readily met by community providers and who are likely to need long-term, if not lifelong, secure care.

There are a number of people who have been under the Framework and in hospital-level secure care for upwards of ten years. This includes seven of the twelve service users who informed my investigation. I acknowledge that DHB staff do their best to support these service users in ways that will help them achieve their maximum level of independence. It is clear from the records for each of these service users that DHB staff regularly turn their minds to this.

Some service users in this category, including Adam and Jason, have been detained in unsuitable hospital accommodation for ten years, with significant constraints on their quality of life.[95] This is inconsistent with their rights under the Disability Convention.

During my investigation, it also became clear that a significant proportion of people who are under the Framework at any given time are autistic or display autistic traits, in addition to having an intellectual disability.[96] This includes five of the seven people referred to above, who have been in hospital-level secure care for more than ten years. The physical environment in hospitals presents particular challenges for people with autism. It is not difficult to see how a busy, noisy, and crowded hospital ward might trigger anxiety or stress and an escalation in challenging behaviours. In terms of the social environment, people with autism generally need both the opportunity to interact with others and a space to retreat to if the environment becomes overstimulating. In addition, the need for stability and predictability means that it is important to have consistency of staff, and for changes in staffing to be managed in a highly planned way.

One person with autism, Jasper, has lived in a forensic mental health unit for much of his adult life. It was in an effort to provide Jasper with a quieter, more controlled environment that he ended up living largely in a designated seclusion area for around five years.

95 See page 66 for details of Adam's and Jason's experiences.

96 Autism is a neurodevelopmental disability that affects the way people think, feel, interact with others, and experience their environment.

Jasper

Jasper, aged in his forties, has spent more than 18 years living in a forensic mental health unit.

It is widely acknowledged that Jasper's intensive support needs are incompatible with his lengthy placement in the unit.[97] I have previously commented on Jasper's situation in my capacity as a National Preventive Mechanism.[98] Jasper has sensory sensitivities, and is particularly reactive to sound. He enjoys walks around the hospital campus.

After several behavioural incidents, Jasper was moved from the main part of the unit into a seclusion room. He spent much of his time in a seclusion lounge listening to the radio and watching television. At times, Jasper was spending *'up to 22 hours of the 24 hour day … with little or no interaction with others'*.[99]

Although community transition options were explored for Jasper, none were successful. One proposal involved putting a relocatable two-bedroom unit on a property with an existing residential service. The proposal fell through after the provider received advice from the Ministry and another party that the unit was not financially viable.[100] Approximately one year after the first proposal, planning began with another community provider around adding a wing to an existing home. After additions were made to the house, there were concerns that the building layout would prevent staff from safely exiting if an incident were to occur, and Jasper's transition was unable to proceed.

Around two years after Jasper was moved into a seclusion room, a District Inspector formally investigated Jasper's situation. The District Inspector held that Jasper's detention in the mental health unit breached his right to receive medical treatment and other healthcare appropriate for his needs. In addition, Jasper's lengthy time in seclusion breached his right to the company of others.[101] The District Inspector recommended that, as a matter of urgency, consideration be given to the creation of a specialised facility more appropriate for the safe management of Jasper and other people with similar intensive support needs.

After receiving intensive behavioural support, Jasper moved out of the seclusion area, where he had been for four years, into the main part of the unit. DHB staff supported Jasper to leave his bedroom and spend time in the communal living room with other service users.

In 2020, the Ministry approved a plan that will enable Jasper to move to an individualised home in the community.

97 There have been comments by District Inspectors, several clinicians and DHB staff about the inappropriateness of Jasper's placement. At interview, the Ministry acknowledged that Jasper's life would improve if he were living in the community.

98 In my role as a National Preventive Mechanism, under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), I visit places of detention to help ensure that New Zealand meets its obligations under international law to prevent any form of torture or ill treatment of people who are detained by the State. After an inspection, I make recommendations to improve the treatment of detainees and conditions of detention. These independent inspections are an important part of the checks and balances to prevent human rights breaches in places of detention. I have undertaken a number of inspections of Framework facilities, including hospital- and community-level services.

99 Support Needs Assessment (unpublished, January 2011).

100 Email from residential community provider manager to residential community provider staff regarding unit (9 April 2010).

101 Pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 66 and 71.

Women and youth service users

Women and youth service users are minority groups within the Framework. When Framework services were established, there was an expectation that very few women would become care recipients,[102] and youth were not included. As a consequence, their needs were not specifically planned or provided for.[103] The establishment by Capital & Coast DHB of the National Youth Service Hikitia Te Wairua provided a specialist service for the Central region only.

However, women with intellectual disabilities have made up a reasonable proportion (up to 15 percent) of Framework service users. All five DHBs providing hospital-level services have accommodated women. Many female service users live with trauma histories and other coexisting mental health needs. Some, like Alison and Kirsty, have been in hospital facilities for a prolonged period of time.

Alison and Kirsty

Alison's and Kirsty's experiences illustrate issues posed by the Framework's current service configuration.

Alison is aged in her sixties. Aside from two short periods in community homes, she has resided in various forensic units in her home region for almost thirty years. In 2012, Alison transitioned to a step-down facility. Since her move, Alison has been supported in a two-bedroom area at the facility. The use of the adjacent bedroom cannot be accessed by male service users.

Attempts to transition Alison to a community placement have been unsuccessful, due in part to her own wish to remain at the facility and funding issues. Unexpectedly, however, Alison flourished when she temporarily moved back to the secure service's main ward during the COVID-19 level 4 lock-down in 2020. The DHB supporting Alison noted that she enjoyed having contact with other female service users on the ward. Leading on from Alison's positive experience, plans for her transition to a community home are again underway.

Kirsty, aged in her fifties, has been in a hospital-level secure service for more than five years. She has also spent time living apart from others. Between 2017 and early- to mid-2019, Kirsty lived alone in a four-bedroom area. This had an impact on the placement of other, male, service users.

In late 2019, another female service user moved into Kirsty's area, and they have continued to share this space.

As admission to Hikitia Te Wairua is limited to care recipients, I understand most, if not all, DHBs have on occasion accommodated young service users in their adult facilities for the purposes of assessment. Since late 2016, higher referral volumes have put pressure on FCS(ID) to locate appropriate placements for youth. FCS(ID)'s ability to coordinate placements is complicated by the lack of dedicated youth facilities outside Wellington.

102 Draft National Bed Strategy, version one (unpublished) at 15.

103 Although there was some provision for women to be transferred to Capital & Coast DHB under the 'National Women's Contract', this contract was not fully operationalised.

UNCROC provides that young people in detention *'shall be separated from adults unless it is considered in the child's best interest not to do so'*.[104] The Ministry stated that UNCROC issues most commonly occur when service users at Hikitia Te Wairua reach the age of 18, and remain there as 'adults' alongside youth for a short period of time. This was the case with Finn, who moved from Hikitia Te Wairua into an adult unit after an adjustment period.

Finn

Finn, aged in his twenties, is from the South Island. At age 16, he was admitted to the National Youth Unit Hikitia Te Wairua. While there, he participated in therapeutic activities and attended a mechanics course. Finn's family advised that, although they kept in daily contact with Finn over the phone, it was difficult to travel from the South Island to visit him.

After he turned 18, Finn remained at Hikitia Te Wairua for around one month before transferring to a hospital-level secure service for adults. He was subsequently discharged and returned to live with his family.

When caring for service users of different genders and ages, DHBs must balance the benefits of social interaction versus risks. Some service users have a history of sexual offending, and continue to present a high risk to others.[105] A degree of separation between males and females is often required for safety purposes.[106] Most DHBs have managed the risks through using separate areas (if available) and increasing staffing levels to 1:1. One DHB has used inpatient mental health service beds to accommodate women.[107]

Placement and transition processes

As previously noted, FCS(ID) is responsible for coordinating the placement of Framework service users into, and between, hospital- and community-level facilities on behalf of the Ministry.

The FCS(ID) Resource Manual includes operational guidelines relating to funding, eligibility and process, legislation, and the provision of care and rehabilitation. The guidelines are updated intermittently, as required.[108] For example, the FCS(ID) *Eligibility and Process Guidelines* state that, after a person enters a service, they are reviewed on a regular basis with the goal of reintegration into the community.[109] The processes for managing the interface between hospital- and community-level services, and other agencies, are not stepped out in the guidance material.

104 UNCROC, art 37(c). New Zealand *'has also reserved the right not to apply article 37(c) in circumstances where the shortage of suitable facilities makes the mixing of juveniles and adults unavoidable; and further reserves the right not to apply the Article where the interests of other juveniles in an establishment require the removal of a particular juvenile offender or where mixing is considered to be of benefit to the persons concerned.'* Ministry of Justice "UN Convention on the Rights of the Child", above n 31.

105 DHB staff members and District Inspectors confirmed that they were aware of several incidents of inappropriate contact between service users, including sexual assaults.

106 Protecting the health and safety of care recipients and others is one of the two key principles of the IDCCR Act (see s 11(a)).

107 Waitematā DHB advised that since 2017, it has accommodated women in the adjacent mental health facilities, and reserves Pōhutukawa Unit for its male population. Some DHBs reserve clusters for women, which impacts on their ability to accommodate other service users.

108 FCS(ID) confirmed that its guidelines were reviewed during 2020, and revised guidelines have not yet been issued.

109 Forensic Coordination Service (ID) *Eligibility and Process Guideline* Version 2.1, October 2018 (unpublished), at 8.

I found that there have been considerable tensions between FCS(ID) and DHBs around some placement decisions. FCS(ID) stated that relationships and processes were implemented equitably and consistently across the country, and noted that many aspects of operational process are defined by legislation. However, several DHBs and community providers considered that there was insufficient collaboration and transparency around placement decisions, including the level of information provided about proposed placements. Some Framework providers identified a need for clear, consistent, and agreed operational processes for the placement of service users. One DHB stated:[110]

> *There appears to be national inconsistency regarding how FCS operates which results in some lack of clarity of its role within this DHB. We consider the Ministry has a role ensuring that Care Co-ordination and FCS relations with DHBs are uniformly delivered nationwide. We also consider that the national work streams relating to the High and Complex Needs were very constructive in building sector relationships and promoting greater national consistency and would welcome further opportunities to engage in appropriate collaborative projects.*

In terms of transition to the community, the process of FCS(ID) negotiating a community placement and transition plan can take considerable time, commitment, and financial resources. The transition itself is usually a staged process, and may take several months after the transition plan has been agreed. I understand the Ministry may become involved in the negotiations, including if there are funding or other issues to resolve.

In some cases, particularly for service users with the most complex needs, it has taken many years to successfully negotiate a transition plan with a community provider. Several DHB staff expressed the view that it would be helpful if they could be more closely involved. One community provider commented that their involvement, and receiving more information at an earlier stage in the process, would be beneficial. They also identified the need for more intensive packages of care to be available, with wrap-around support for community placements.

Several of the case studies illustrate the challenges in planning the transition of service users from hospital to the community. See for example, Jasper's story[111] and Mike's experience as detailed below.

110 Letter from DHB to Chief Ombudsman (29 January 2021).

111 See page 51 for Jasper's story.

Mike

Mike, aged in his fifties, spent more than ten years living in a hospital-level secure service. Mike's transition to a community placement took six years to eventuate. Records indicate a multitude of delays, extended periods of funding negotiations, and communication issues.

Around six years after Mike was admitted into the hospital-level service, discussions were held by FCS(ID) and a community service provider around supporting Mike to move to a community placement. Funding was sought from the Ministry to undertake modifications to an existing residential property. Soon after, matters were put on hold, as there was high demand for the property in question.

FCS(ID) and the provider eventually resumed negotiations, and, over a three-year period, continued to discuss prospective service provision.

The Ministry met with FCS(ID), the DHB supporting Mike, and the community provider in an effort to expedite Mike's transition. The parties agreed that, within a month, a plan would be formulated around building modification options and pricing, and a proposal would subsequently be submitted to FCS(ID) for consideration by the Ministry.

Although the proposed renovation plan was completed, uncertainty remained around the funding arrangements for the required building modifications. Subsequently, the referral to the provider was formally withdrawn, with the stated reason being the provider's inability to invest funds in the property, given that the Ministry was not in a position to supply additional funding.

Seven months later, the Ministry began discussions with another community provider. The provider advised that then *'there was about a year of negotiation with all parties and the Ministry'*, culminating in an agreement and funding arrangement.[112] About a year after that, Mike moved into his home.

When my investigation team met with Mike, he was clearly delighted with his new home and being able to live in the community. I do not doubt that the DHB supported Mike to the best of its ability while he was under its care. However, it is clear that the individualised support he receives in a community-based home provides much greater opportunity to maximise his quality of life.

As the result of the various challenges and issues identified with Framework service delivery above, it appears that Ministry staff became heavily involved in a number of individual service user placements. However, the Ministry's stewardship role of the New Zealand health and disability system extends beyond individual case management. In my view, it requires that the Ministry oversees the system as a whole and takes a long-term view of the system (by taking reasonable steps, actions, and decisions to protect the future public interest of that system) and to address any systemic issues that arise. In the following section of my report, I outline my findings about the extent to which the Ministry discharged its stewardship responsibilities.

112 Community provider interview.

Figure 11: Activities room at Te Whare Manaaki.

Part 3: Framework performance: the role of the Ministry as system steward

It is in the context of the background set out in Part 1: Background to the Framework and Part 2: Status of the Framework that I considered the Ministry's administrative actions and decisions in relation to the Framework, particularly as system steward. As stated above, I considered how the Ministry managed the Framework in terms of planning, taking action, monitoring and reviewing, and providing free and frank advice.

In general, I expect the Ministry's **planning** to involve setting clear short-, medium- and long-term objectives and determining how to achieve those objectives. It involves deciding what to do, how to do it, when to do it, and who will do it. Planning is highly variable in nature, depending on the purpose, scope, and duration of an activity or programme. However, as system steward, the Ministry was best placed to have the whole-of-system view.

Taking **action** is about the Ministry's implementation of measures intended to remedy any identified problems or otherwise sustain and improve a process or system.

Monitoring involves the Ministry collecting and using information to assess and review system performance, often against an agreed plan. In essence, monitoring is a means of determining whether an activity is operating effectively and meeting its objectives. In order to be robust and consistent, a system of agreed indicators (criteria or descriptors) may be used to measure the service delivered against the desired outcomes. Monitoring measures accountability for

the expenditure of public funds. However, responsible monitoring by a system steward should also extend beyond auditing contractual compliance and supporting providers to improve their performance. Rather, I would expect the Ministry to be critically analysing relevant information in order to maintain and improve system performance.

Systems may also require full **evaluation.** This would involve the Ministry taking a comprehensive look at the effectiveness of a policy or programme, to determine whether an adjustment to its overall direction is needed. Outcome evaluation is the systemic attempt to measure the impact of government intervention on outcomes. Evaluation is:[113]

> *…an essential means of learning how policies or programmes are being implemented, identifying where improvements are needed, ensuring that the policies or programmes in which we have invested are achieving desired outcomes, and of holding particular organisations (or groups of organisations) to account for achieving outcomes.*

Finally, comprehensive, reliable information and robust analysis provide the basis for good quality 'free and frank' **advice** to inform ministerial decision-making. In order for the Ministry to provide free and frank advice to its responsible Ministers, the Director-General should be able to rely on good quality advice being given at every level of the Ministry. This forms the basis for further planning or actions to improve systems. This includes providing comprehensive information about available options (benefit, cost, and risk) in respect of any decision the Minister is being asked to make. It also includes longer-term policy stewardship, through advice that identifies future challenges and opportunities. The Public Service Commission's *Free and Frank Advice & Policy Stewardship* noted that building the capacity to provide quality strategic advice is a challenge for systems, as well as a legal responsibility:[114]

> *Consideration needs to be given to the appropriate level of investment in developing future-focused capability. This includes investing in agency capability, contributing to pooled investment in sector or system groups' shared capability and supporting, funding or engaging with external experts who contribute research and analysis (for example, academics, think tanks or other institutions). Mature policy stewardship is embedded throughout policy teams and processes rather than relying on dedicated teams or individuals.*

Planning

In looking at planning, I have considered both the high-level strategic planning I would expect to see in respect of the Framework, and the planning that occurred to address identified problems when they became apparent—in particular, the increasing capacity pressure in both hospital- and community-level services.

As outlined earlier, in terms of hospital-level secure services, the Service Coverage Schedule of the Crown Funding Agreement confirms that the Ministry must plan for the type and quantity of services needed, in collaboration with DHBs.[115] The Ministry is obliged to make reasonable efforts to resolve any gaps in Framework service coverage by planning for appropriate action.

113 Jaqueline Cumming and Sharleen Forbes "Better Public Services: the case for monitoring and evaluation" (August 2012) 8(3) *Policy Quarterly* 49 at 53.

114 State Services Commission *Acting in the Spirit of Service: Free and Frank Advice and Policy Stewardship* (December 2017) at 3.

115 Ministry of Health *Service Coverage Schedule 2020/21*, above n 45, at 1.

The Ministry's planning should be informed by the New Zealand Disability Strategy and the Disability Action Plan, which aim to eliminate barriers to enable disabled people to reach their full potential.[116] This includes implementing the Disability Convention and reducing the use of seclusion and restraint.

On the basis of the information I have considered, it appears to me that the key planning work undertaken by the Ministry relevant to the operation and performance of the Framework comprised:

- work on a National Bed Strategy between 2015 and 2017;
- work undertaken through the High and Complex Framework Project from late 2018; and
- wider cross-Directorate planning from 2019 onwards.

Draft National Bed Strategy (2017)

In 2015, the Ministry started working on a 'National Bed Strategy' for the Framework. In 2017, Ministry staff prepared a report setting out a draft strategy. The report stated that the Framework had matured considerably since 2004 and *'the Ministry is well placed to detail the development that needs to take place over the next five years. A priority issue to be addressed is an acute bed shortage within hospital level services.'* The report noted the risk that the Ministry would not be able to fulfil its statutory obligations due to the inability to place people under IDCCR Act orders. It stated further:

> *A short-term plan will be detailed that will address acute hospital level bed availability over the next two to three years.*
>
> *A second subsequent document will be developed that will identify developmental needs across the HCF in the medium term. The identified objectives for the HCF will ensure the ongoing sustainability of the HCF and maximum rehabilitative outcomes for the individuals we support.*

The short-term plan (1–2 years) detailed in the draft report was essentially to:

- reallocate under-utilised beds, by transferring the funding for three fee-for-service beds in the Central region to the Northern region;
- purchase additional beds in Auckland (Northern region); and [117]
- develop a national service of individualised service units for high-needs service users across both intellectual disability and mental health services.

The draft strategy was not finalised. The Ministry advised me that the draft report was not shared with the DHBs at the time due to the sensitive nature of the information and potential contractual implications, and the short-term plan was not finalised due to *'the pressures becoming more acute and the redistribution of beds no longer being viable'*.[118]

116 I note that both the strategy and action plan were updated during the period I have looked at for this investigation. The New Zealand Disability Strategy 2016–2026 was issued in November 2016 and preceded by the New Zealand Disability Strategy 2001. The Disability Action Plan 2019–2023 was issued in November 2019 and preceded by the Disability Action Plan 2014–2018. Refer to Appendix 5 and Appendix 6 for more information.

117 The intention was to purchase an additional eight step-down beds from Waitematā DHB. This would require the DHB to develop a business case for a capital build for board approval. It would also require the Ministry to approve funding for the operating costs (that is, to contract the additional beds).

118 Letter from the Ministry of Health to Chief Ombudsman (3 February 2021).

High and Complex Framework Project (late 2018)

In late 2018, the Ministry set up a joint DHB/Ministry Oversight Group to work on the development of an agreed action plan to address systemic capability issues across the Framework.[119] The Oversight Group identified three key areas of focus: Model of Care, Workforce, and Optimal Environments. A sub-group was formed for each area, and action plans were proposed. The intention was that the 'High and Complex Framework Project' (Framework Project) would run for 18 months until early 2020, at which point the Ministry would undertake further action as required.

The Framework Project was focused on hospital-level secure services as a starting point, and did not include community-level residential services—although the intention was to bring them in at a later stage. Ministry staff stated that the three sub-groups had extensive overlap, and the work would eventually come together as 'one plan'.

In broad terms, the objectives of the sub-groups were as follows.

- Model of Care – to develop a national model of care for hospital-level secure services.
- Workforce – to develop a nationally agreed workforce development plan, to be resourced and implemented by the Ministry in collaboration with key stakeholders, resulting in a more skilled, supported intellectual disability workforce with less staff turnover.[120]
- Optimal Environments – to identify what makes an optimal inpatient environment for supporting people under the Framework, including providing environments that allow for the least restrictive interventions and the greatest quality of life for service users. This group aimed to produce an options paper that could be used to support DHBs make capital bids.

By mid-2020, the initial period of the Framework Project came to an end, with the following outcomes.[121]

- The National Model of Care was moving into the implementation phase. The NGO Te Pou was to receive additional funding of $160,000 for Positive Behaviour Support training.[122]
- The majority of the Workforce sub-group deliverables had not been progressed, and additional support was needed to progress action in this area. A training programme for statutory appointees under the IDCCR Act would be incorporated into the National Model of Care.
- The Optimal Environments sub-group had identified gaps and issues for each DHB, but otherwise had not progressed the deliverables for infrastructure planning.
- Additional actions identified by the Oversight Group had not been progressed and would require additional resource. This included involving community services in planning, reviewing contract specifications/outcomes, demand modelling, cross-DHB forums, and reviewing the functions that sit with FCS(ID).

The Ministry stated that some of the outstanding actions would be integrated into the cross-Directorate work, with input from the Disability Directorate as required.

119 This occurred following meetings between the Director-General and the chief executives of the DHBs providing secure services. The Ministry noted that between 12 September 2018 and 16 October 2019, there were five such meetings.

120 Ministry of Health DSS High and Complex Framework Working Group *Workforce sub-group Work Plan* (unpublished, 28 August 2019).

121 Internal Ministry memo to Deputy Director-General Disability (unpublished, 30 July 2020).

122 See Appendix 9 for further information about Health Workforce and Te Pou.

In October 2020, the Ministry notified members of the Oversight Group that only the Model of Care sub-group meetings would continue. The Ministry stated that it would advocate for a *'continued focus'* on workforce issues. It also stated that Framework planning would be expanded, and that a further project plan would be developed to include community services. It was noted again that other aspects of planning were being integrated into cross-Ministry work. This included the work of the Optimal Environments sub-group, which was integrated into the wider forensic capacity planning work—more specifically the National Asset Management Programme and the National Forensic Capacity Project (see below).

By late 2020, the Ministry was in the process of recruiting a project manager and developing a project brief for the ongoing planning work.

Wider cross-Directorate planning projects

National Asset Management Programme (2018)

In 2018, the Ministry began work on the National Asset Management Programme (NAMP) to enable more informed capital investment decisions. The intention of the programme is stated as establishing a national framework that outlines the condition of DHB infrastructure, which the Ministry can use as a prioritisation tool for capital spending on remediation work and planning for new facilities.

Due to be finalised in 2022, the NAMP will enable the Ministry to understand the state of DHB buildings and form a clear view on the issues. In a more strategic approach, the Ministry and Treasury will set national priorities, facilitate more regional coordination between DHBs, and support business cases aligned with the NAMP.

The first NAMP deliverable, *Report 1: The current state assessment (Report 1)*, was released in June 2020.[123] It provided a standardised assessment of selected hospital buildings, concluding that much of New Zealand's hospital infrastructure needs improvement.

In June and September 2020, Clinical Facilities Fit for Purpose (CFFFP) assessments were carried out on all hospital facilities. The forensic facilities scored amongst the worst, with the facilities for people with an intellectual disability considered to be in the very worst condition. The quality of the environments was found to be poor, with a number of physical factors that were assessed as not therapeutic. Southern DHB's Ward 10A and Canterbury DHB's AT&R Unit were seen as particularly challenging and suboptimal environments. A sample of concerns raised in the individual DHB CFFFP reports (September 2020) is included in Appendix 8.

123 Ministry of Health *The National Asset Management Programme for district health boards: Report 1: The current-state assessment* (10 June 2020).

The National Forensic Framework (2020)

In August 2020, the Ministry decided to extend the scope of a National Forensic Framework project, being led by the Mental Health Directorate, to include intellectual disability.[124] This is a three-part project designed to review and provide guidance on all aspects of the five Regional Forensic Mental Health Services.[125] However, the Ministry subsequently confirmed that late in 2020, the Framework was taken out of this project.[126]

The National Forensic Capacity Project (2020)

In early 2020, the Ministry established the National Forensic Capacity Project. This project is led by the Capital Investment Management Group in consultation with the Mental Health Directorate and the Disability Directorate. An undated *'description of works'* stated:[127]

> *The current bed state for both disability and mental health forensic hospital facilities has reached acute capacity, with several of the five regions operating at over capacity. We are currently unable to directly admit to forensic hospital beds, and this impacts our ability to meet statutory requirements. Further acute mitigation in conjunction with ongoing wider term planning is required with urgency.*
>
> *Addressing forensic capacity and understanding clinical fit for purpose and future models of care is a critical programme of work that the Ministry is embarking on.*

The purpose of the project is to deliver a capacity plan and options paper for future investment in forensic capacity across New Zealand, including mental health and intellectual disability. It will include demand modelling for the number of service users and beds, incorporating models of care to establish what hospital services are needed. It will result in costed-up operational and capital investment options, to address the capacity constraints geographically.

In August 2020, Ministry staff stated that the investment options to address the capacity need will be relatively high level, but should be sufficiently specific to use as the basis for a budget bid. There will be caveats on the data for intellectual disabilities due to data gaps, which will be worked through using assumptions. The project will have a strong focus on the 'pipeline' from hospital to community, including how many beds are needed. The infrastructure focus will be on DHB facilities.

Ministry staff stated that there is scope for this plan to be merged with the CFFFP assessments to create a Mental Health Asset Management Plan, to include all forensic facilities with fully costed investment scenarios.[128]

124 For the avoidance of doubt, this is separate from the High and Complex Framework Project described above.

125 These are provided by the same DHBs that provide forensic intellectual disability services. The project includes models of care, care pathways, and the interface between courts, prison, community, and forensic services.

126 The Ministry advised there were several reasons for this, including that the Mental Health and Disability Directorates had identified significant differences between the needs and care pathways of the two service user groups (mental health and intellectual disability), and that shared issues relating to the environment were covered off in the forensic capacity planning work and the NAMP process.

127 Attached to email from the Ministry of Health to Chief Ombudsman (9 June 2020).

128 The Mental Health Asset Management Plan would serve as an intermediary to the full NAMP, which is tagged for completion in 2022. Alternatively, the capacity plan could be handed over to the Mental Health and Disability Directorates for further action.

Findings

On the basis of the information I have considered so far, I found that during the period covered by my investigation (2015–2020), the Ministry did not have or develop a cohesive overall plan for the delivery and development of the Framework, which specified intended outcomes and promoted the New Zealand Disability Strategy.[129] I note that the Disability Support Services Strategic Plan 2014 to 2018 confirmed Disability Support Services responsibility for the planning and funding of disability support, but did not include any specific references to the Framework.[130] Ultimately, the Framework is the means by which the Ministry ensures the needs of a specific group of people with an intellectual disability are met. I am concerned that, as the system steward, the Ministry did not appear to appreciate the need for an overarching, comprehensive plan to guide its work. The need for such a plan was, in my view, all the more acute as problems with the Framework's operation and performance intensified.

As noted above, the Ministry attempted to develop a national bed strategy between 2015 and 2017, but never finalised it. The Ministry attributed this to the fact that the pressure had become more acute, and the redistribution of beds was no longer viable. While I understand why the reallocation of beds to the Northern region was no longer considered viable, the fact that pressure was intensifying was, in my view, a reason to **increase** efforts to develop a comprehensive plan and consider additional measures that might address the problem. I understand that a second document, intended to identify the Framework's medium-term developmental needs, was proposed by the Ministry but not prepared. Instead, it appears these efforts were largely abandoned, with the focus shifting to the Framework Project—the collaborative planning process set up with the five DHBs in late 2018.

It is my view that the Framework Project was useful in terms of collaborative planning. However, the sub-groups were not focused on the capacity issue. The Service Coverage Schedule, which sets out the level of service coverage for which the Ministry and DHBs are held accountable, states that the Ministry and DHBs *'should work together to ensure resolution of service coverage gaps'*.[131] I consider that the Ministry should have engaged with the DHBs in respect of the problems evident in the operation of the Framework much sooner than it did, and that this should have included the capacity issue. As the funder and planner of Framework services, and the party best placed to have a complete picture, the onus was on the Ministry to lead that engagement.

The DHBs told me clearly that they would welcome more regular engagement with the Ministry, to gain an increased understanding of sector issues. As one DHB noted in its comments on the Framework Project:[132]

> *There was a sense of some cohesion across the country and a will to work collaboratively towards longer term planned solutions. This initial central leadership was, in essence what the DHBs needed rather than reactive or divisive approaches driven by crises.*

In terms of what the Framework Project **did** achieve, by the end of 2020 the Model of Care sub-group appears to have been a success, and the Ministry is continuing to support the implementation process. However, the Workforce and Optimal Environment sub-groups were

129 See n 116. As noted in Appendix 6, the Disability Strategy is identified as the government's vehicle for meeting Disability Convention obligations.

130 Ministry of Health Disability Support Services Strategic Plan 2014 to 2018 (June 2015).

131 Ministry of Health *Service Coverage Schedule 2020/21*, above n 45, at 1.

132 Letter from DHB to Chief Ombudsman (28 January 2021).

not well positioned to achieve their objectives or bring about the necessary change. In effect, their work was limited to issue identification, and meaningful outcomes have not resulted. As one DHB commented:[133]

> *It is the view of the clinical teams that the reason for the success of [the Model of Care sub-group] is that there was a clear Model of Care provided by Capital and Coast District Health Board which provided a robust framework for the Models of Care work group to review, amend, and agree. The other work streams have struggled to reach this point, and the complexity of the work streams and work loads of both DHB and Ministry participants appear major contributors to this.*

The Framework Project was set up in response to concerns raised formally and collectively by the five DHBs providing secure services. No such concerns were raised by the providers of community-level services. The fact that the Framework Project did not include community-level services meant that issues relevant to the interface between these and hospital-level services were not progressed through the collaborative planning process. The critical importance of these linkages is clearly evident from the experiences of several of the service users whose experiences I looked at for this investigation. In the meantime, capacity and capability problems in community-level services escalated. I am concerned that the Ministry appears to have only recently turned its attention to how these might be addressed. The Ministry acknowledged that in retrospect it should have engaged sooner with providers of community-level Framework services.[134]

In terms of the more recent wider Ministry planning work, the Ministry stated that the National Forensic Capacity Plan was specifically intended to include both mental health and intellectual disability services. I note that while there are undoubtedly advantages to planning for forensic intellectual disability services being done in conjunction with forensic mental health services—there are needs, challenges, and indeed service users in common—it is important that the specific requirements for services for people with an intellectual disability are not overlooked. This is a much smaller group of people, who have not, in my view, received the requisite level of attention in terms of planning. I note also that as the National Forensic Capacity Plan has a longer-term focus, it does not appear to be a mechanism to address immediate needs.

DHBs consistently identified workforce issues such as training and competencies, career pathways, and recruitment as areas of significant concern. However, the ongoing Framework planning work does not include workforce issues in any meaningful way. I consider that the Ministry should have continued with planning in this area, in order to support DHBs to deliver the agreed model of care.

The National Bed Strategy was intended to provide solutions to the increasing bed pressure in hospital-level secure services. It was replaced by less targeted and much longer-term initiatives. It appears that, in some respects, the lack of urgency accorded to resolving the capacity issue by the Ministry was obscured by the Framework Project and the work of the three sub-groups. Given the increasing shortage of beds and the concerns about deteriorating capability, I consider the Ministry could reasonably have been expected to develop a more robust and timely strategic response, akin to a revised national bed strategy.

The capacity crisis did not arise overnight. The Ministry had clear, ongoing evidence of increasing pressure from before 2015. From early 2017, FCS(ID) was reporting that the Framework was in crisis. Shortly after, the DHBs spelled out the extent of their concerns. In the absence of substantive

133 Letter from DHB to Chief Ombudsman (29 January 2021).

134 Letter from the Ministry of Health to Chief Ombudsman (14 May 2021).

action by that point, the spate of requests since around July 2018 for the deferral of court proceedings should certainly have prompted a more urgent corrective response. In my view, the Ministry's efforts to develop a plan for a more targeted, acute response were inadequate.

Actions

In next looking at the Ministry's actions over 2015–2020, I have considered what measures it implemented to address problems with the Framework's operation and performance or otherwise improve it.

I understand the main actions taken by the Ministry during the period I have looked comprised:

- a Budget bid in 2015/16;
- support for development of individualised service units;
- demand modelling;
- funding for additional beds at Waitematā DHB; and
- the standardisation of rates paid to DHBs for secure care beds.

2015/2016 Budget bid

In 2015/2016, the Ministry made an unsuccessful attempt to obtain additional funding for Framework services. This was made in the context of a disability support services' cost pressure Budget bid.[135]

In relation to the Framework, the bid described the pressure being experienced within the Framework at that time, particularly within hospital-level secure services. It referred to the fact that bed capacity issues were resulting in an inability to meet requirements under the IDCCR Act. It noted that there was a small number of people who could not be safely managed within current hospital-level secure environment and who required the use of management techniques such as seclusion, representing a potential breach of their rights. In its bid, the Ministry noted that:

> *[This had] resulted in attention from the United Nations [Committee on] the Rights of Persons with Disabilities, the Health and Disability Commissioner and the Office of the Ombudsman. Specialised beds are required to meet the needs of these high risk individuals long term.*

I understand that, had the bid been successful, the additional funding would have gone towards addressing cost pressures in the disability budget, and, in terms of the Framework, towards purchasing additional beds at Waitematā DHB, subject to infrastructure expansion.[136]

I understand that in the remainder of the period I have looked at for this investigation, the Ministry did not submit any further bids for Framework-specific funding.

135 The available documentation shows that the Ministry sought an additional $1.6 million per annum for the Framework and an additional $63 million overall. The Ministry received an increase of around $30 million overall for the disability budget. In Budget 2020/21, the Disability Directorate received a $100 million funding increase in order to address price and volume pressures. This was intended to return the funding of disability support services to a sustainable level.

136 Ministry emails to Waitematā DHB, and Ministry staff interviews.

Support for Individualised Service Units

As noted above, the Draft National Bed Strategy included a proposal to develop a national service of Individualised Service Units (ISUs) for high needs service users. This related to a proposal by Capital & Coast DHB, originally put forward in 2015/16, to build six ISUs adjacent to the Haumietiketike Unit for a small number of high-risk, high-profile service users from across the country. These were to provide individualised care for service users needing the highest level of support due to their mental health and/or intellectual disability. This group of long-term service users is estimated to include around four to eight people across the country.

In 2017, the Ministry obtained approval from the Capital Investment Committee to progress a business case for the building of individualised units.[137] In August 2018, the Government announced capital funding of $8 million for the ISUs.

The ISUs were due to open in early 2020. However, the project was delayed for various reasons, including the need to undertake internal modifications to Haumietiketike. Construction of the ISUs commenced in September 2020, and is now expected to be completed towards the end of 2021.

137 The Capital Investment Committee is an advisory committee appointed under s 11 of the NZPHD Act. It provides advice to the Ministers of Health and Finance, and to the Ministry, on capital investment and infrastructure in the public health sector.

Adam and Jason

Adam and Jason transferred to hospital-level secure service after their respective clinical teams identified that a change in environment would allow for a better quality of life and supported transition to a community setting. Both Adam and Jason are aged in their thirties, and have been considered for placement in the Individualised Service Units (ISUs).

Soon after his admission, Adam engaged in challenging behaviour and was taken to a seclusion room. He remained there while a behaviour management plan was developed. Adam began to spend long periods outside of seclusion. He developed an interest in growing his own produce, which he sold to staff. A serious assault later halted his progress.

Jason was placed in the secure service's main unit. He was able to participate in some activities, and enjoyed living there. However, as Jason's experience of Tourette Syndrome affects his ability to control his body movements, Jason was regularly secluded after committing impulsive assaults on staff. In 2012, Jason was moved into his own separate area in the main unit.

As time progressed, Adam's and Jason's care teams began to consider options for their long-term placement. Adam's family expressed concern that he was continuing to live in the seclusion area, and a District Inspector was informed about his situation.

Records show that, around 2015, FCS(ID) and the Ministry discussed the possibility of supporting Jason in a specialised unit for people with intensive support needs, which Capital & Coast DHB was looking to establish.[138] Adam was also considered for the unit.

By 2016, plans for the new facility had been drawn up; however, funding approval for the development and construction was still needed. That year, face-to-face contact with Jason was suspended after he assaulted a staff member from the secure service. In order to grow Jason's social opportunities, the DHB obtained a belt restraint which Jason could put on and take off himself.[139] Later in 2017, Jason started using a second restraint, designed to be used for therapeutic support outside of his area.

In mid-2018, funding for the ISU proposal was approved by the Ministers of Health and Finance. Work on the units was scheduled to take place after Capital & Coast DHB carried out building renovations.

In late 2020, Adam moved from the seclusion area into a bedroom, where he currently lives. Adam's family said that Adam has been detrimentally affected by the lengthy period he spent in seclusion. They noted that Adam has been very frustrated by his circumstances.

So far, Jason has continued to reside in his own separate area. He is able to use his restraint to participate in activities such as van rides beyond the hospital grounds.

138 Emails between the FCS(ID) and the Ministry of Health (19 November 2015).

139 In the event that Jason's behaviour escalates, staff or visitors are able to remove themselves to a place of safety before Jason has removed the belt.

Demand modelling

In terms of demand modelling, the Ministry undertook the following actions.

1 As part of the draft National Bed Strategy, the Ministry analysed bed utilisation data for each DHB. The Ministry noted that the total number of hospital-level secure service beds had grown from 47 beds in 2007 to 66 beds in 2017, and there was an increased need for secure services, particularly in the Auckland region, which required further discussion with Waitematā DHB.

2 The Framework Project's Optimal Environment sub-group identified demand modelling as an action for the Ministry. By March 2019, the Ministry had completed some analysis of historic data, but future modelling had not commenced.[140] Ministry staff interviewed stated that they had limited ability to progress this work due to competing priorities.

Demand modelling for the Framework was subsequently incorporated into the National Forensic Capacity Plan.[141]

Funding for additional beds at Waitematā DHB

From mid-2018, the Ministry funded up to three additional beds at Waitematā DHB's Mason Clinic for specific service users on a supernumerary basis.[142]

In July 2020, the Ministry advised Waitematā DHB that a contract variation had been approved to capacity fund five additional beds, which were to become available on a medium-term basis through the redevelopment of the Mason Clinic site.[143] This included the three beds then purchased on a supernumerary basis, so the actual increase in capacity was two beds.

E Tū Tanekaha is a 15-bed medium secure mental health unit currently under construction on the Mason Clinic site. The Ministry advised that Waitematā DHB 'formally signalled' the possibility this project would entail additional beds being available for intellectual disability service users with the Ministry in late 2019, although it is evident that this possibility had been raised prior to that, in July 2018.[144]

Correspondence indicates that the Ministry initially signalled its interest in the additional beds, but, for more than a year, little happened and no firm commitment was entered into. I understand that in the absence of a commitment or any meaningful evidence of interest from the Ministry, Waitematā DHB extended a similar offer to mental health services.[145]

140 The DHB bed data showed that the average duration of stay was 18 months, and 33 percent (13) of the 40 current care recipients had been in care for more than seven years.

141 See page 61 for information about the National Forensic Capacity Project.

142 Supernumerary funding is the purchase of additional beds and associated services in excess of capacity-funded or fee-for-service beds (person-specific).

143 This was formally confirmed in a letter dated 6 August 2020. These beds are expected to be available until one of the existing units on the Mason Clinic site (the Kahikatea Unit) is decommissioned, which is not expected to happen for at least 4–5 years.

144 Correspondence from Waitematā DHB's then clinical director to the Ministry's Group Manager, Disability, dated 24 July 2018, states:

Against this background we are currently progressing a building programme … to replace existing building stock which is no longer fit for purpose. We are also working with the Ministry to secure additional land so that we can continue to meet the Government's expectations going forward. You will appreciate that it is very hard to make investment decisions for the long term without greater clarity about the services we will be expected to provide. While we may not have immediate solutions to assist the capacity problem, we are in a position to discuss intermediate term forensic ID bed expansion possibilities at Mason Clinic, which could be available as early as March 2020.

145 Waitematā DHB staff interviews.

In late 2019, the Ministry asked Waitematā DHB at short notice to submit a proposal, which it did. In July 2020, the Ministry confirmed its intention to purchase the five additional beds.[146]

As noted previously, one component of the draft National Bed Strategy was the addition of step-down beds for Auckland (Northern Region). On the basis of the information provided to me, there was no progress on a step-down service at Waitematā DHB during the period under investigation.

Standardised contract rates

As of 1 July 2020, the rate at which the Ministry pays DHBs for secure service beds (bed/day rate) was standardised, with all DHBs now paid at the same rate.[147] Prior to this, bed/day rates for the Southern, Canterbury and Waikato DHBs were significantly lower than for Capital & Coast and Waitematā DHBs.[148] I note this had been a further source of dissatisfaction for some DHBs. The standardisation was the result of a review of the DHB contracts to *'align funding and ensure that the numbers and types of beds meet the future needs of the High and Complex Framework'*.[149]

Canterbury DHB, in particular, had raised with the Ministry its concern about the rate at which it was paid and the fact that its bed/day rate was low relative to other DHBs. In early 2019, Canterbury DHB advised the Ministry that its intellectual disability service was effectively being subsidised by mental health services funding to the value of over $1 million, and that this was a funding shortfall that threatened the viability of ongoing service provision. Senior managers advised my investigators that the Board seriously considered exiting its intellectual disability services contracts, but did not proceed due to concern about the impact on its service users and the lack of alternative services.[150] More recently, Canterbury DHB advised that for the 2020/2021 financial year, the provision of Framework services will cost approximately $400,000 more than the funding received (not including overhead costs). As such, the DHB effectively cross-subsidises by using its health service population-based funding to meet the shortfall. Canterbury DHB noted that the use of its population-based funding to build four new pods was effectively another example of cross-subsidisation.

Findings

Notwithstanding my concerns mentioned in the previous section about the lack of planning, I found the Ministry did take some action between 2015 and 2020 in an effort to improve Framework performance. However, in the context of the known problems, including potential breaches of the Disability Convention, I am not satisfied that the Ministry's actions were timely, or sufficient to meet its responsibilities and accountabilities, as the planner and funder of disability support services and

146 The Ministry advised that Waitematā DHB was informed in early 2020 that the Director-General had given approval for the purchase of additional beds to be progressed, but that the internal memo required to get formal agreement to the contract variation was delayed due to COVID-19. The Ministry stated that the DHB was advised on 21 July 2020 that the contract variation had been approved.

147 The standardisation did not affect the rates paid for assessment beds, fee-for-service beds, step-down beds (Capital & Coast and Southern DHBs only) or AT&R beds (Canterbury and Southern DHBs only).

148 The standardisation represents increases of 55 percent for Southern DHB and 67 percent for Canterbury and Waikato DHBs.

149 Correspondence from the Ministry of Health to Canterbury, Waikato and Southern DHBs (unpublished, 15 July 2020).

150 Senior managers advised further that—having initially been told by the Ministry a business case was being prepared to enable funding equity across the DHBs—in March 2019, it was informed that the request for a funding increase had been declined. In May 2019, the Ministry wrote to all disability providers advising that, notwithstanding the funding increase for disability support services (up from $42 million in 2016/2017 to $72 million for 2019/2020), it was not able to fund any pricing increases or additional investment in that financial year. The Ministry explained further that the additional funding was required to meet the areas of greatest demand, which were *'a combination of price and volume pressures right across disability services'*.

as system steward. I am particularly concerned that the Ministry did not act to identify, investigate, and present to decision makers other options to address the capacity pressure in the short and medium term, pending the development of longer-term solutions.

While DHBs are responsible for their own infrastructure development, the support of the Ministry is critical to getting projects started. Although the Ministry recognises this, I consider that in the context of the Ministry's overarching responsibility to understand, plan, and lead, it could and should have provided DHBs with more tangible support, which they could have used to initiate and progress business cases for service expansion. For example, the Ministry advised me that it had undertaken demand modelling work on two or three occasions during my investigation period, to better understand future demand.[151] However, I found no evidence that the Ministry completed analysis of this nature that the sector could rely on to determine how many more beds were required, and that DHBs, in particular, could draw on to develop and progress agreed business cases. I received consistent feedback from DHBs that the level of uncertainty around this, and the absence of an infrastructure plan, impacted on their confidence and willingness to invest resources in the development of business case proposals for new or expanded facilities.

In general, it appears to me that DHBs have dealt with their respective infrastructure needs without the Ministry's close involvement or support. All of the DHBs providing hospital-level secure services have facilities with environmental limitations that impact significantly on the delivery of care and rehabilitation to service users, and on the health and safety of their staff. Although the Ministry worked in close partnership with Capital & Coast DHB, including in relation to the ISUs, staff from other DHBs described a sense of alienation from the Ministry. They advised me they felt excluded from any planning and development work the Ministry was engaged in.

In terms of the five additional beds at Waitematā DHB, I note that the Ministry formally confirmed its intention to purchase these just over two years after the DHB had indicated their potential availability. The delay was unhelpful for the DHB in terms of its forward planning and risked the opportunity being lost altogether if, in the absence of a commitment from the Ministry, the DHB had decided on alternative use for those beds. The additional beds will provide further placements for service users under the Framework in the Northern region, with the caveat that they are not within a specialist intellectual disability unit. As three of the beds purchased were already being funded on a supernumerary basis, the overall effect will be an increase of two beds. While this is useful, it will not significantly reduce capacity pressure in the Northern region. It is surprising that during the period covered by my investigation, the Ministry did not properly quantify the number of additional beds needed in the Auckland region. The lack of a step-down service in this region—a component of the discontinued National Bed Strategy in 2017 and, it would seem, long accepted by the Ministry as necessary—has yet to be addressed.

The Ministry stated that aligning the bed/day rate for hospital level secure services from 1 July 2020 will significantly contribute to the financial sustainability of the regional services (that is, Canterbury, Southern, and Waikato DHBs). While this may be so, it has taken a significant number of years to achieve this. The three DHBs providing only regional services have therefore been placed in the position of accommodating service users whom they were never set up to care for, including a number of long-term service users with very high, specialised support needs.[152]

151 See page 67. In January 2021, the Ministry advised me that it had undertaken demand modelling on two occasions and further modelling was in progress. In its response to my provisional opinion (letter dated 14 May 2021), the Ministry advised demand modelling was undertaken in 2018, 2019, and 2020.

152 As outlined on page 34, the Service Specification states that people requiring a high-security environment and/or medium- to long-term placements should go to the national services provided by Capital & Coast DHB and Waitematā DHB, and the other three DHBs should deliver services for people during the assessment phases of court proceedings.

This has contributed to significant ongoing operational deficits that the DHBs have been required to manage internally. The disparity in bed rates was drawn to the Ministry's attention on multiple occasions. At least two DHBs contemplated exiting their secure services contracts. Given the intense pressure on beds, the withdrawal of a DHB from the Framework would have been highly problematic, not least for the affected service users.

The completion of Capital & Coast DHB's ISUs for service users with the highest support needs will provide an additional six beds. This should allow for movement within the Framework and provide a better quality of life for some service users. The Ministry stated that the ISUs will have a significant impact on the operational capacity of the Framework, as they will accommodate individuals whose needs are such that it has not been possible to use other bedrooms located in the same area.[153] However, the extent to which the ISUs will resolve the capacity issue is unclear to me. First, they are not exclusively for service users with intellectual disabilities. Second, some service users would find it extremely distressing to be separated from their families if required to live away from their home region. At least two of the service users interviewed for this investigation and/or their families talked in some detail about the difficulties they experienced—mentally, emotionally, practically, and financially—when living in different parts of the country.

Monitoring

The Ministry's monitoring obligations are a continuous aspect of its wider stewardship role, which includes effective monitoring of the Framework, irrespective of any competing demands. This requires the Ministry to collect and review information and to consider how to mitigate any system performance issues. In order to consider how the Ministry has discharged its monitoring obligations, I have considered the information collected by the Ministry, and the processes for reviewing that information.

Information collected

During 2015–2020, the Ministry collected information about Framework services, and the overall operation of the Framework, from a range of sources.

Provider Performance Monitoring Returns

DHBs and community providers of Framework services are contractually required to supply six-monthly reports to the Ministry, known as Performance Monitoring Returns (PMRs).[154] These reports include data about the total number of beds occupied per month, and any additional information about critical incidents, issues, and highlights. (There are separate reporting obligations concerning seclusion and restraint, and young service users, which are discussed below.) PMRs are also provided to FCS(ID) and are used to inform its quarterly reporting to the Ministry.

The practice of DHBs and FCS(ID) has been to report to the Ministry on a quarterly basis. Prior to 2016, all DHBs submitted quarterly reports using a Ministry template. The data included the number of assessments, referrals, care and rehabilitation plans, discharges, occupied bed days, and the total number of current service users. The narrative component in most reporting was relatively minimal and focused on critical incidents.

153 Letter from the Ministry of Health to Chief Ombudsman (3 February 2021).

154 See n 56 for further information about the contract service specifications.

My understanding is that, in 2016, DHB reporting became less standardised. One DHB stated that there was no longer a formal requirement to provide PMRs, as there was a change to outcomes-based reporting. It also advised that there was no longer any template in use, and reporting was primarily focused on direct communication with the Ministry about significant events. Since then, while bed utilisation data and serious incidents are still reported, my understanding is that the Ministry has not reintroduced standardised operational reporting on a regular basis.

A community provider stated that they had ceased reporting *'outside the contract'*, and the Ministry did not query the lack of narrative report when they stopped providing it.

Ministry staff interviewed also confirmed that the reporting by providers of Framework services was neither comprehensive nor consistent. They said it was difficult to understand the magnitude of the issues being experienced, as the Ministry was receiving only *'bits of information'*.

FCS(ID) reporting

FCS(ID) has a specific role in relation to collecting information about Framework service delivery. As set out in the contract service specifications, this involves 'same day' reporting to the Ministry about significant issues and quarterly reporting on a range of matters including:

- whether the services being delivered are meeting the needs of individual service users;
- gaps in services available from providers; and
- any unresolved issues, problems, complaints, or significant risks with the services delivered by contracted providers.

Ministry staff regard FCS(ID) quarterly reporting as providing the most comprehensive view of Framework performance. The information produced by FCS(ID) means that the Ministry does not need to compile bed utilisation data itself. The Ministry has access to the FCS(ID) spreadsheet showing current and proposed referrals into the Framework.[155] The Ministry noted that this enables both FCS(ID) and the Ministry to maintain an understanding of potentially unmet demand.[156]

Ministry audits and other quality assurance mechanisms

The Ministry audits DHB and community providers of intellectual disability services.[157] The Disability Directorate routinely commissions audits and developmental evaluations of Framework services against their contracts. These are separate from, but undertaken in alignment with, the audits undertaken by the regulator HealthCERT, against the Health and Disability Services Standards.[158]

The Ministry stated that its audit and evaluation programme ensures regular visits to providers *'with a focus on quality improvement, achievement of quality of life outcomes and the safety of people who use their services'*.[159]

155 FCS(ID) is usually alerted to proposed referrals through its liaison with the court, but there are occasions when unexpected referrals occur.

156 Letter from the Ministry of Health to Chief Ombudsman (14 May 2021).

157 See n 59 for further information about the service specifications.

158 HealthCERT is responsible for ensuring a reasonable level of health and disability services, including compliance with the relevant New Zealand Health and Disability Services Standards.

159 Letter from the Ministry of Health to Chief Ombudsman (14 May 2021).

The Ministry also obtains information about the quality of Framework services through processes for reporting and following up on critical incidents and complaints, and through the regular contact by the Portfolio Manager responsible for Framework services.[160]

Sector engagement

The Ministry also collects information about the Framework through direct engagement with the providers of Framework services and other stakeholders. There was a significant level of engagement relating to bed availability and the placement of specific service users, due to the shortage of beds. As noted earlier, the Ministry is responsible for managing and addressing any **serious** unresolved issues between FCS(ID) and service providers.

Seclusion and restraint

The Ministry collects information from service providers on the use of seclusion and restraint in intellectual disability services from several sources.[161] Some providers submit data to the Ministry's Programme for the Integration of Mental Health Data (PRIMHD)—a national mental health and addiction database—while others report data manually by way of a spreadsheet. The Ministry receives some seclusion data directly through provider reported critical incident notifications.[162] These are reviewed by the Quality Team and any issues of concern addressed. The FCS(ID) quarterly reports include seclusion and restraint events as part of the critical incident log.

There are complexities around capturing DHB seclusion data that affect the Ministry's ability to collect and report consistent, comprehensive information. Some IDCCR Act service users, for example, are coded identically to forensic mental health service users in PRIMHD, as they are detained in forensic mental health facilities. The Ministry is working with DHBs to report data relating to these two groups separately. I note that this data was separated out in the Office of the Director of Mental Health and Addiction Service's Annual Report 2017,[163] but not in the recently published report for 2018 and 2019.[164]

The Ministry advised that it had collected seclusion data for people under the Framework for the years 2017 to 2019, and that it would be undertaking analysis of that data to ascertain trends over time.[165]

To assist with my investigation, the Ministry compiled seclusion data relating to Canterbury DHB, Capital & Coast DHB, Waitematā DHB and Southern DHB between March and April, for 2018 and for 2020. Although the data suggested a general reduction in seclusion rates, I was unable to draw any meaningful conclusions from this information, due partly to inconsistencies between the information provided by the Ministry, FCS(ID), and the DHBs.

While the Ministry collects and intermittently collates information about seclusion and restraint in DHBs, it does not have a process for continuously tracking or analysing that information. An undated internal memo states that the Ministry *'has been aware for some time of the need to review the way ID seclusion data is collected',* including the need for disaggregated data for Framework service users.

160 See n 58 for further information about critical incidents.

161 See Appendix 11 for more information on seclusion and restraint.

162 See n 58 for further information about critical incidents.

163 Ministry of Health *Office of the Director of Mental Health and Addiction Services Annual Report 2017* (February 2019).

164 Ministry of Health *Office of the Director of Mental Health and Addiction Services Annual Report 2018 and 2019* (March 2021).

165 Letter from the Ministry of Health to Chief Ombudsman (14 May 2021).

UNCROC reporting

The Ministry receives information from service providers about young people, for the purpose of monitoring service provider compliance with UNCROC. A key area of focus is the placement of young people in facilities with adults, or *'age-mixing'*. As discussed earlier, Article 37(c) of UNCROC sets out *'every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so'*.[166] In order to assist service providers to interpret Article 37(c), the Ministry produced Guidelines for Compliance with Non Age-mixing Provisions in Article 37(c) of the United Nations Convention on the Rights of the Child.[167]

In terms of UNCROC reporting, a Ministry staff member advised that, in practice, FCS(ID) and service providers informally report incidents of age-mixing to the Ministry *'once every few months'*.

In response to my information request, the Ministry provided a spreadsheet of age-mixing notifications, along with other documentation. My review of the Ministry's information showed that:

- from 2016 to 2019, there were 18 age-mixing breach notifications;
- most breaches were generated by providers of community-level services;
- the average age of a young person placed with adults was 16; and
- the oldest person had recently turned 18 and was temporarily living at Hikitia Te Wairua, and the youngest was aged 15.

The placement of young people in adult forensic units should only occur if there are appropriate reasons. The Ministry adds reports of age-mixing to a folder.

I observed a number of instances where there was no apparent follow-up by the Ministry, to check whether and, if so, when, an alternative arrangement had been made or what, if any, mitigation measures had been put in place to ensure the safety of the young person. The Ministry advised that UNCROC non-compliance events are usually reported to the Ministry both orally and in writing, and the matter is followed up to resolve the breach. The Ministry stated that it is notified by FCS(ID) when non-compliance events occur and are resolved.[168]

District Inspector reporting

The Ministry receives regular reports from District Inspectors with information about Framework service users, including where specific concerns about their rights under the IDCCR Act have arisen.[169]

166 Subject to New Zealand's reservations.

167 Ministry of Health *Guidelines for Compliance with Non Age-mixing Provisions in Article 37(c) of the United Nations Convention on the Rights of the Child* (unpublished, approved October 2005). For instance, the Ministry must be notified of all instances where young people aged under 18 are placed in an adult unit, and an adult is placed in a young person's unit, and disability services and Directors of Area Mental Health Services are responsible for reporting critical incidents on a quarterly basis, which includes cases of age-mixing.

168 Letter from the Ministry of Health to Chief Ombudsman (14 May 2021).

169 See for example, Jasper on page 51 and Bryan on page 42.

OPCAT Inspections

As noted earlier, in my role as a National Preventive Mechanism under the United Nations Optional Protocol to the Convention against Torture (OPCAT), I visit places of detention to help ensure that New Zealand meets its obligations under international law to prevent any form of torture or ill-treatment of people who are detained by the State. I provide a copy of my reports to the Ministry. The Ministry has assured me that my reports are always reviewed and recommendations are taken seriously, and that specific issues are likely to be followed up with District Inspectors or entered into the quality monitoring processes. The Ministry noted that there is regular communication with District Inspectors both individually and collectively on a bi-monthly basis, and this includes discussion of any potential rights breaches. Concerns raised by District Inspectors are specifically followed up with providers.

Framework facilities

In my 5 March 2020 *Report on Waikato DHB's Puna Maatai Unit, Henry Rongomau Bennett Centre*, I expressed concern that the placement of service users with an intellectual disability in forensic wards compromised their care and limited their opportunities for rehabilitation.[170] I recommended that staff receive training including for service users with an intellectual disability.

In my 30 October 2018 *Report on an unannounced inspection of Canterbury DHB's Assessment, Treatment and Rehabilitation Unit (Hillmorton Hospital),* I identified that the facility was not fit for purpose.

In my 30 October 2018 *Report on an unannounced inspection of Canterbury DHB's Te Whare Manaaki Unit (Hillmorton Hospital)*, I identified serious concern about the inappropriate placement of two service users with intellectual disability in the unit. I stated:[171]

> *Whilst commending staff for their work in attempting to improve the lives of Patients A and B, Inspectors consider that the Unit is not a suitable facility for patients with an [Intellectual Disability]. Such patients often have complex needs, which require the attention of staff with the necessary experience and expertise to ensure that they are able to live as full a life as possible while in hospital.*

I recommended that service users with an intellectual disability should be accommodated in facilities that meet their needs.

170 National Preventative Mechanisms *Report on an unannounced inspection of Puna Maatai Forensic Inpatient Ward, Waikato Hospital, under the Crimes of Torture Act 1989* (5 March 2020).

171 National Preventative Mechanisms *Report on an unannounced inspection to Te Whare Manaaki Unit (Hillmorton Hospital) Under the Crimes of Torture Act 1989* (30 October 2018) at 13 (Released by Canterbury DHB in response to an Official Information Act 1982 request to the DHB).

Review of information

Aside from having specific duties to review contractual compliance by providers of Framework services, the Ministry, by virtue of its stewardship role, should also undertake a more systemic, proactive review of the performance of the Framework. In order to do this, the Ministry should have a clear documented methodology or process for analysing the material it collected. However, the Ministry's systems and processes for reviewing information about Framework services and the Framework's overall operation were somewhat difficult for me to ascertain. I did not receive any information to satisfy me that there was a formal monitoring framework in place. It appears that the oversight was undertaken on an ad hoc basis, with no processes for trend analysis.

In particular, during my investigation, Ministry staff reported that the resource available for responding to Framework performance issues was limited, with the Chief Advisor IDCCR and portfolio managers undertaking the systemic review function only when time permitted, and without the involvement of the Strategy, Policy and Performance team.

Ministry staff interviewed also stated that, in general, they were too busy to review and analyse information, and develop proactive responses to manage Framework issues. They stated that engagement with DHBs was useful in understanding the issues and helped improve relationships, but there was no clear resolution pathway for longstanding issues, notwithstanding the planning work done through the Framework project from late 2018. Ministry staff interviewed stated that the situation was complicated by DHBs and community providers struggling with their own difficulties.

Ministry staff also stated that fiscal pressure on the Ministry affected the level of consideration given to increasing bed numbers. I note that, in contrast, the Director-General advised me separately that while there were concerns about the availability of sufficient resources to support the Framework, it was his view that *'these could be addressed through the Ministry's internal prioritisation processes'*.[172]

Findings

Monitoring is a key tool for maintaining confidence in the performance of the Framework, and for enabling any performance issues to be proactively addressed. Above and beyond contractual compliance, I consider that the Ministry has an obligation to continuously track Framework performance to identify emerging trends (including risks, challenges, and opportunities) and to review how to respond. As part of that monitoring, it is crucial that the rights of Framework service users are acknowledged and addressed. It is also important that the Ministry maintains accurate and reliable records of what information it collects and how it responds.

I have found that the Ministry did not have an adequate monitoring system in place. There was no shared understanding between the Ministry and Framework providers of how to measure progress or develop collective action to address systemic concerns. It is imperative that this is rectified as part of the ongoing process of improvement. The first task is to establish a collective understanding of outcomes and how those are to be measured.

In terms of the information collected by the Ministry, Framework provider reporting focused heavily on bed occupancy numbers and incidents. Although this information covered financial accountability and risk, I do not consider that it provided a comprehensive picture of Framework performance. There was no consistent reporting across the Framework regarding service delivery, processes, or outcomes. There were no nationally consistent outcome measures for Framework services, and the Ministry did not take steps to ensure that reporting was standardised.

172 Letter from the Ministry of Health to Chief Ombudsman (3 February 2021).

There appeared to be no process in place to measure and track unmet need. As a result, the information the Ministry collected about Framework capability was patchy. It was not sufficiently comprehensive to enable the Ministry to undertake periodic trend analysis or to maintain a level of confidence that therapeutic outcomes were being maximised for all service users.

Ministry staff stated that they relied on less formal communications to understand the issues because sector reporting was inconsistent and often incomplete. The issues included the difficulties in accepting new referrals into unoccupied beds, the adequacy of the facilities, and workforce issues. This indicates that the information obtained from Framework providers did not adequately cover all the relevant aspects of service delivery. Sector engagement was necessary in order to fully understand particular issues. In my view, the Ministry gave insufficient attention to ensuring that it was collecting all the relevant information necessary to maintain a view of Framework issues, and to determine how to collectively address the systemic issues.

As noted earlier, on the basis of the information I have considered, it seems to me that there was no overall plan against which to assess Framework performance. It is more difficult to evaluate policies and programmes where the outcomes have not been identified, and contract reporting is not aligned with those outcomes. However, the Ministry was positioned to maintain a broad view of sector issues, including the capacity issue. FCS(ID) reporting provided a longitudinal view of sector capacity **and** FCS(ID)'s perspective on capability issues. The Ministry was fully aware of the inability of Framework services to appropriately accommodate a small group of those service users with specialised support needs. For example, the draft National Bed Strategy noted that the development of individualised solutions for these service users would *'not only mitigate the unintentional breach of rights it would allow for greater capacity in the larger system'*.[173]

As well as being inconsistent and unstructured in terms of overall trends and themes, sector reporting had limited reach in terms of the rights of individual service users and outcomes. Neither DHB or FCS(ID) reporting nor Ministry audits focused on outcomes for individual service users despite this being a very small and extremely vulnerable cohort of people. Nor was there evidence of reports relating to the rights of individual service users being collated into a central repository, despite ongoing concerns. Taking a closer interest in service users' outcomes would enable the Ministry to more proactively address issues of concern through review and planning processes. Otherwise, there is a risk that improvements to Framework services, processes, and outcomes are only prompted by critical incidents. This is unlikely to result in Framework services that meet the needs of people with very high support needs, including those with autism.

Given New Zealand's obligations under the Disability Convention, I also consider that the Ministry should have more closely monitored the group of service users whose needs were not properly anticipated when the Framework was established. This includes services users with very high support needs, women, and young service users accommodated outside the National Youth Unit. Given the risk that this group of service users would either not have the best opportunities to develop their strengths and capabilities, or would be unsafe, I consider that additional oversight was required. Aside from case management by FCS(ID)'s care coordinators, there appears to have been no system or process in place for the Ministry to monitor this group of service users. Some of them—particularly those with high support needs—have remained in hospital-level secure care for many years. Some in this group are subject to indefinite orders under the Mental Health Act, and as a result their detention is not subject to the oversight of the courts. This makes it even more

173 Draft National Bed Strategy, above n 102, at 19. At that time, the Ministry was in the process of preparing a business case for the ISUs.

important that the Ministry monitor their progress, irrespective of FCS(ID) case management. While the transition of longer term service users into the community is complex, there appears to be a need for more clearly defined care pathways, including between services.[174]

The processes for the collection and review of data about seclusion and restraint were not robust. In 2017, the Government announced its intention to eliminate the use of seclusion in mental health services by 2020. This should have signalled to the Ministry that it needed to urgently improve its data collection, analysis, and review of seclusion rates in intellectual disability services as well. I also note that a key recommendation of the third report of the Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities was that the government:[175]

> *Strengthen the commitment to reduction of rates of restraint of persons with disabilities, and the rapid reduction, towards elimination, of use of seclusion in secure health and disability facilities, through robust, achievable and time-bound policies.*

While the Ministry is aware of its shortcoming in this regard, the Ministry advised that it had now collected data over several years and would be completing further analysis to ascertain trends over time.[176] To date however, I have seen no evidence that it has taken sufficient steps to address this issue. The quality of data collection and review was not consistent with Article 31 of the Disability Convention.

While the Ministry assures me that recommendations I make in my capacity as a National Preventive Mechanism under OPCAT are taken seriously, the extent to which these, and the reports of District Inspectors, are effectively acted upon appears variable.[177]

Overall, it seems to me that the Ministry's monitoring of the Framework has been limited to crisis management. Instead of monitoring overall system performance and outcomes for individual service users, the Ministry focused on crisis-based individual referral management and case-by-case negotiations with individual providers. The ongoing analysis, review, and development of systemic options for improving Framework performance informed by robust data was markedly absent, and there was no roadmap or plan for how this would occur. The lack of shared national outcome measures for the Framework is a gap in the system that compromised the Ministry's ability to proactively respond to and address systemic issues.

Advice

As outlined earlier, the provision of free and frank advice by a chief executive to their responsible Minister and to Cabinet is one of the five fundamental public service principles and an explicit responsibility in the Public Service Act.[178] Te Kawa Mataaho Public Service Commission, the Department of the Prime Minister and Cabinet, and the Cabinet Office have issued inter-linking guidance on developing effective free and frank advice.[179] In summary, the principles of good quality advice include:

174 A care pathway is a way of setting out a process of best practice to be followed in the care of people with particular needs.

175 New Zealand's Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities *Making Disability Rights Real Whakatūturu Ngā Tika Hauātanga: 2014–2019*, above n 22, at 14.

176 Letter from the Ministry of Health to Chief Ombudsman (14 May 2021).

177 See for example, Jasper on page 51 and Framework facilities information.

178 Public Service Act 2020, ss 12(1) and 52(1); see also s 32(1)(f) of the former State Sector Act 1988.

179 See Department of the Prime Minister and Cabinet "Free and frank advice" (27 November 2020) for a summary of guidance issued by Te Kawa Mataaho Public Service Commission, the Department of the Prime Minister and Cabinet, and the Cabinet Office.

- context that explains the nature and significance of the policy issue;
- analysis that is clear, logical, and informed by relevant research and evidence;
- advice that assesses the options with clear impacts (benefit, cost, and risk) of solutions, and;
- action to enable implementation, monitoring and evaluation.

In terms of *when* advice is required, the following applies.

- Cabinet papers are required for matters of public interest, importance, or controversy.[180]
- Chief executives must inform Ministers of any significant developments within their portfolios (the 'no surprises' principle) and provide them with information and advice, to enable Ministers to set policy priorities and objectives.[181]

Similar principles apply to internal departmental advice—the provision of good quality of advice by a chief executive to Ministers and Cabinet relies on the provision of free and frank advice at all levels of an organisation. Te Kawa Mataaho Public Service Commission *Frequently Asked Questions on Free and Frank Advice & Policy Stewardship* states:[182]

> *Ultimately each chief executive is responsible for tendering free and frank advice — this is for them or their delegates to decide, not for other employees to decide independently. However, to achieve this, chief executives rely on free and frank advice being the norm at every level of its development.*

I have set out below my consideration of the advice the Ministry provided about Framework performance, both internally and to the Minister.

Briefings to the Director-General of Health

The information shows that the Director-General of Health received written briefings on the Framework capacity issue from 2018 onwards. The Ministry confirmed that there were no written briefings provided to the previous Director-General for the 2015–2017 period, when the capacity issue was emerging.[183] Nor were there any written briefings provided to the Minister during that time by the Ministry. The Ministry advised that there were internal discussions about capacity pressures during the 2015–2017 period, which were escalated to the Group Manager for Disability Support Services and the Director for Service Commissioning, who also discussed the issue with the Director-General at the time.[184]

On 6 July 2018, the Director-General was advised that the bed capacity issue was becoming more pronounced, and there were no available hospital-level beds. The Ministry would continue to monitor the situation and work with providers to alleviate pressures. In response, the Director-General made the following handwritten comment:

> *Issues and problems noted, also noted request to meet. However, most pressing is a need for advice on short and medium term options to manage the risk to the providers and most importantly the risk of compromising care of individuals. It would be most useful to meet once we have some options to discuss.*

180 Department of the Prime Minister and Cabinet *When is a Cabinet paper required* (18 July 2017).

181 Department of the Prime Minister and Cabinet *Ministers and the public service* (24 June 2017).

182 Te Kawa Mataaho Public Service Commission, Frequently Asked Questions on Free and Frank Advice & Policy Stewardship (December 2017) at 1.

183 Letter from the Ministry of Health to Chief Ombudsman (3 February 2021).

184 Letter from the Ministry of Health to Chief Ombudsman (14 May 2021).

On 30 October 2018, a written update to the Director-General stated that the five forensic DHBs had been asked to nominate representatives for the three sub-groups set up under the Framework Project.[185] The groups would develop a range of short-, medium- and long-term options, and the Ministry would continue to collaborate with individual DHBs.[186]

On 28 February 2019, the Director-General was provided with an update. The memo noted the need *'to move from a reactive mode into a more forward looking approach that identifies short, medium and long term solutions'*. Alongside the work of the sub-groups, the Ministry stated that it intended to complete demand modelling work. The other proposed actions including reviewing the national contracts, convening a DHB national forum, reviewing Framework processes, and including community services in planning.

In November 2019, the Mental Health Directorate and the Disability Directorates updated the Director-General regarding *'acute capacity pressure'* within forensic mental health services and the Framework. They recommended establishing a joint work programme, with a view to expanding the capacity of forensic services. The memo stated (emphasis added):

> *The current bed state for both disability and mental health forensic hospital facilities has reached acute capacity, with several of the five regions operating at over capacity. This has placed the Ministry of Health in the position of not being able to provide necessary beds for the completion of forensic assessments for individuals who have either an intellectual disability or mental health needs. We are currently unable to admit to forensic hospital beds, and this impacts our ability to meet statutory requirements.* ***Further acute mitigation in conjunction with ongoing wider term planning is required with urgency.***

The memo outlined practical proposals to mitigate the capacity pressure in mental health services, and, for intellectual disability services, referred to continuing Framework planning work. The proposals for the Framework were focused on longer-term improvement to be achieved through the Framework Project sub-groups. The Director-General received a briefing on 10 December 2019 regarding the proposal to purchase additional beds in the Auckland region. Although further briefings at that level were intermittent, the Deputy Director-General Disability was kept informed about Framework planning initiatives, including the National Forensic Capacity Plan.

On 30 July 2020, the Deputy-Director General Disability was provided with an update on the status of Framework planning work and wider Ministry work programmes for alleviating capacity pressure. The memo stated that the situation remained critical, and the Ministry was engaging with the sector to work towards appropriate solutions. The memo confirmed that funding between DHBs was now aligned, but other proposed actions, including demand modelling, had not been progressed.

In October 2020, in the context of the spike in absconding incidents, the Director-General was advised that there were significant bed pressures within the community-level services. Due to capacity and capability issues, those services were becoming *'increasingly unable to manage complex and risky individuals'*. The briefing provided an update on wider cross-Directorate work and Framework planning, and stated that the Framework planning would be extended to include community-level services (as proposed in the February 2019 plan).

185 The sub-groups are discussed on page 59.

186 The Director-General and DHB Chief Executives met on 12 September and 12 November 2018, after which a steering group maintained oversight of the sub-groups.

Community provider capability

Towards the end of 2020, there were a number of service users who absconded (sometimes repeatedly) from one community provider. Some were not able to be located and the absconding was reported to the police, and arrest warrants were issued. At least one of the people who absconded presented risks to the safety of others. The Ministry was closely involved in supporting the provider to ensure that security was adequate, and that absconding was handled appropriately.[187] The decision was made that it would not be appropriate to return several of the service users to community-level secure care. The plan was for them to be placed into custody, if they were located and arrested before beds became available in a hospital-level secure care facility.

Another community provider stated that they had maintained their capability, and their capacity to accept secure and supervised care recipient referrals had been under-utilised. They considered that the cause of pressure on community services was due to an increase in service user complexity, without any corresponding increase in wraparound support for community placements. They also commented that long-term service users could be considered for community placement if more intensive packages of care were provided, including access to specialist services.

The Director-General requested a further briefing on what steps were being taken in the interim, while medium- and longer-term solutions were being developed. On 26 November 2020, he was advised that, as well as individual referral management, the Ministry would work closely with community-level providers to identify and address any impact on their ability to provide services. The memo included specific strategies for identifying potential opportunities for investment to support ongoing development and increase capacity within community-based services.

On 18 December 2020, the Director-General received an update focusing on community-level services. The briefing advised:

- the Ministry was continuing to explore options for the placement of the care recipients who had absconded;
- additional resources had been allocated for Framework planning work; and
- a meeting would be held to progress planning work and develop investment strategies.

Briefings to the Minister

Aside from a briefing relating to an official information request in May 2017, I found that written updates to the Minister about the Framework capacity issue commenced in 2018, following the appointment of the current Director-General. These were presented as being for information purposes only. Ministerial briefings prepared by the Ministry concerning Framework capacity issues included the following.

187 This issue needs to be seen in the context that facilities providing community-level secure care are not as physically secure as hospital facilities. The Secure Services Matrix requires secure community facilities to have locked doors but not to be 'escape-proof'. The security is more reliant on staffing and relationships than in hospital-level secure facilities.

- In July 2017, in the context of an official information request, the Minister of Health was advised that the Ministry had been aware of bed pressure for Framework service users across the country for some time. The Ministry was continuing to work with DHBs to manage resource constraints.
- In October 2018, the Ministry advised the Minister's Office that, although capacity pressure had been managed by careful referral management, *'all regions are now operating at capacity'*, and the Ministry was seeking a second deferral of a hearing where the likely outcome for the person was referral for assessment under the IDCCR Act.[188] The Ministry agreed to continue to keep the Minister updated.
- From mid-2018 until early 2019, capacity issues under the Framework regularly featured in the ministerial weekly report. These briefings were for noting only, with no decisions required. For example, the briefing for September 2018 included:[189]

> *As previously advised, operational capacity for hospital-level forensic services has reached maximum levels as a result of an increased number of court referrals, higher care recipient acuity and staffing pressures within the five forensic DHBs.*
>
> *In order to develop both short and long-term solutions to current pressures in collaboration with DHBs, a national meeting with the five specialist DHB providers and Ministry officials was held on 12 September 2018. The meeting was positive and provided an opportunity for parties to share issues and to gain an understanding of the impact of these issues across the service.*
>
> *Next steps will be to establish:*
>
> - *a working group to include all parties to focus on the short term issues*
> - *a strategic group to develop some longer term solutions for this growing population.*

The reports for October and November 2018 stated that working groups with DHBs would be established to address the capacity issues in the short to medium term. However, further reports stated that the three sub-groups would focus on improving longer-term outcomes under the Framework. In the short term, FCS(ID) and the Ministry would *'take a national approach to bed placement in cases where the local region is unable to deliver'*.[190]

On 10 December 2020, the Ministry provided the Minister with a weekly report item about *'Service delivery and capacity issues in the High and Complex Framework'*. The briefing stated:

> *There is significant pressure across the [Framework], particularly in relation to hospital-level forensic services. This pressure has resulted at times in the inability to provide the necessary hospital-level beds for people referred from the courts for assessment and/or placement under the Act.*
>
> …

188 Email from the Ministry of Health to the office of the Minister of Health regarding the Minister's meeting agenda (22 October 2018). The Ministry noted that it was in discussions with two DHBs and FCS(ID), and it was anticipating that a bed would be available in two weeks, with a combination of discharges and inter-regional transfers.

189 Ministry of Health weekly report items to Minister of Health (14–21 September 2018).

190 Ministry of Health weekly report items to Minister of Health (7–13 December 2018).

In the short term, DHB service pressures remain critical with acute management in place for each individual referral. Planning work includes the development of short, medium- and long-term actions for community-based providers.

The briefing stated that actions from the ongoing planning work with DHBs included:

- the purchase of five additional capacity-funded beds at Waitematā DHB and a new build of individualised service units for high-risk high-needs individuals at Capital & Coast DHB, which will provide an additional six beds; and
- alignment of the bed day rate for hospital level secure services across the five DHBs. This has increased overall funding by $1.7m per annum and will contribute to the financial sustainability of these services and support the provision of a nationally consistent model of care.

The briefing stated that further investment in the Framework would likely include:

- additional community-based capacity-funded beds at Waitematā and Capital & Coast DHBs to support existing capacity;
- one-off funding to support the development of a secure facility in Wellington;
- aligning the funding rate for community providers nationally; and
- increasing capacity by approaching selected community providers to deliver services outside their current region.

Ministry staff suggested that this briefing was provided because the new Minister had not previously been briefed on the issues. Otherwise, there was no particular reason to update the Minister. From December 2020, the Minister was briefed on the care recipients who had absconded and were unable to be located, remaining absent without leave for a period of several months.[191]

Findings

I have identified significant concerns regarding the Ministry's actions and omissions in relation to planning, implementing and monitoring Framework services. Inevitably, this affected the quality of the advice that the Ministry formulated.

In terms of internal advice, in the period between 2015 and 2017 (when it was developing the draft National Bed Strategy), I have found that the Ministry did not provide written internal advice to the Director-General. In my view, it would have been appropriate to formally brief the Director-General on the capacity issue, due to the significant risks and challenges concerning Framework performance. While there may have been verbal briefings and discussions, the lack of written advice has contributed to uncertainty around how the Ministry calibrated its strategic response to the capacity issue.

In mid-2018, the newly appointed Director-General was apprised of the capacity issue, and requested advice about managing the risks. In response, the Director-General was informed that the DHB sub-groups would develop a range of options, and that the Ministry would complete demand modelling and consider other actions.

191 Ministry of Health weekly report items to Minister of Health (1, 8, 15 and 21 December 2020).

Over a year later, in November 2019, the Director-General was advised of the urgent need to mitigate the capacity issue. Although practical options were set out to alleviate capacity pressure in mental health services, the options for Framework services focused on continuing longer-term collaborative planning. The Director-General was not provided with clear advice about mitigating Framework capacity. That type of practical advice was not provided until late 2020 in relation to community-level services. At no stage was practical advice provided to the Director-General about options to mitigate hospital capacity issues. In my view, this was a serious omission.

The development of good quality advice is an iterative process. It may take some time to undertake the necessary research and cost benefit analysis to develop solutions. By late 2019, I consider that advice about the options to alleviate the capacity issue should have been available, **and** advice about longer term solutions should have been well advanced. It was not sufficient to rely on longer-term collaborative planning with the five DHBs to produce solutions.

In short, during the course of my investigation, the Ministry made minimal progress in preparing clear and practical advice to address the immediate capacity issue. Nor did the Ministry pay sufficient attention to developing medium- to long-term options. This represented a failure of the Ministry to prepare good quality advice in a timely manner.

In terms of its obligations to provide free and frank advice to the Minister, I consider that the quality of that advice similarly reflected the limited analysis and review of the capacity issue. I do not consider that the Minister was given sufficiently early notice of the emerging capacity issue. In my view, it would have been appropriate to ensure that the Minister was briefed in writing on the capacity issue in the period when that became evident—around 2015. This would have been consistent with the 'no surprises' principle concerning significant developments in the Health portfolio.

From late October 2018, the Minister was intermittently briefed on the capacity issue, on a *'for your information'* basis. By that stage, matters had already reached the point where the Ministry was unable to provide suitable placement for service users referred by the courts. The Ministry indicated that solutions would be developed in collaboration with DHBs, but did not provide any timeframes for implementation. This was then followed by a relatively significant period of time, from early 2019 to late 2020, when the Ministry did not update the Minister.

The Ministry commented that:[192]

> *The Minister and Associate Minister of Health (and Cabinet more generally) are responsible for setting policy that the Ministry is responsible for advising on, and then implementing policy decisions once they are made. This general approach is reflected in briefings usually being provided to the Minister (and any relevant Associate Ministers) when policy decisions are required, or in response to requests from them for information.*
>
> *This approach means that that there can be long periods during which there are no briefings provided on many aspects of the health or disability support system. That might be because no specific decisions are required, or any decisions that are required are made in response to items in the Ministry's Weekly Report to Ministers, or during meetings between Ministers and officials.*

192 Letter from the Ministry of Health to Chief Ombudsman (3 February 2021).

While there were concerns about whether sufficient resources were available to support the [Framework], this concern could be addressed through the Ministry's internal prioritisation processes. Therefore, there was no requirement for a specific briefing for Ministers on [the Framework].

I acknowledge that the Ministry, like all government agencies, must balance competing priorities and risk. I agree that further advice about policy decisions is not required if policy settings are stable. However, I consider that the capacity issue was a significant matter that should have been brought to the attention of the Minister on a regular basis, until there was a clear plan to address the issues. This presented a significant challenge to the operating environment, and there were significant and increasing risks to the Framework as a whole.

In the circumstances, I consider that the Ministry should have provided clearer advice to the Minister that it was dealing with a situation it was unable to immediately resolve, and that it did not have a confirmed strategy to resolve. The briefings to the Minister gave the impression that although the capacity issue was significant, it was relatively stable and being adequately managed. In fact, as I have set out in this report, the Ministry was increasingly unable to deliver on its stewardship obligations in respect of the Framework.

Overall, I consider the Ministry omitted to develop good quality and timely advice about Framework performance, and did not adequately highlight the urgency of the issues to the Director-General or Minister.

Figure 12: Exercise yard outside Ward 10A at Wakari Hospital.

Part 4: My opinion

As kaitiaki of the health and disability system, and planner and funder of Framework services, the Ministry is accountable for the overall management and performance of the Framework. My investigation has examined whether the Ministry discharged its statutory stewardship obligations by:

- ensuring the system was run effectively within the allocated funding and in line with ministerial expectations (this would include taking all reasonable steps within the available funding to ensure the appropriate placement of service users subject to compulsory care orders);
- identifying the need to increase capacity and capability where necessary, and with a view to the short-, medium- and long-term sustainability of the system (this would include advising on ways to meet any shortfall in services for Framework service users); and
- providing free and frank advice to inform ministerial decisions.

The Ministry's stewardship accountability requires that it maintains oversight of all the component parts of the Framework, and takes a long-term, proactive, collaborative approach to managing and monitoring it, in the public interest. This includes taking timely, proportionate and reasonable steps to ensure it is able to operate effectively. The Ministry must act to ensure that the Framework is able to deliver on intended outcomes.

The Framework problems I have identified, and the capacity pressures, in particular, have worsened over the 2015 to 2020 period explored in my investigation—acutely so since I commenced my investigation in early 2019. There continue to be service users who cannot be placed in appropriate hospital-level secure facilities in their home region, and there are increasingly limited community placement options. There has also been a deterioration in the capability of the system to deliver adequate rehabilitation and care.

While the Ministry was clearly cognisant of the problems, its actions were not sufficiently urgent, targeted, or strategic. I do not consider the Ministry's response was calibrated to reflect the extent to which it was unable to fulfil its system stewardship accountabilities or meet the requirements of the IDCCR Act. As steward of the system, the Ministry needed to develop a clear roadmap to address the capacity crisis and its associated problems. These problems included:

- the deferral of court proceedings resulting in people being remanded in prison until such time as an assessment bed became available;
- the assessment of a person while in prison, contrary to law;
- out-of-region placements;
- the use of mental health facilities for service users who would be more appropriately accommodated in specialist intellectual disability facilities;
- the placement of service users in de-escalation areas and seclusion rooms; and
- ensuring the provision of appropriate services to meet the needs of service users with specialised needs, and of women and youth.

I have found that the Ministry did not have or develop a cohesive, overarching plan to guide the delivery and development of Framework services, which specified intended outcomes and promoted the New Zealand Disability Strategy—and the Disability Convention. There was a lack of planning to address the capacity pressure in hospital-level services as this intensified, and then spread to community-level services.

The Ministry had clear, ongoing evidence of increasing pressure from before 2015. Work on a national bed strategy was started in 2015 but discontinued. It appears that the sub-groups set up under the Framework Project in late 2018 were a positive exercise in collaborative planning, although the outcomes were variable. The success of the Model of Care sub-group shows the value of collaboration in maximising participation and buy-in. However, the Ministry should have engaged with the DHBs in respect of the problems evident in the operation of the Framework much sooner than it did, and this should have included the capacity issue. In addition, the Framework Project did not include community-level services, meaning that issues relevant to the interface between these and hospital-level services were not progressed. It appears that the Ministry has only recently turned its attention to how these might be addressed.

I remain concerned about the extent to which workforce planning has stalled. While the Ministry is looking at re-introducing training for statutory roles through the Model of Care implementation process, measures to address issues with other training, competencies, career pathways, and recruitment and retention have not been identified. The Ministry should, in my view, have continued with planning in this area, to support DHBs to deliver the agreed model of care. I have observed a reluctance by the Ministry to take leadership role in addressing workforce issues, and in my view this has contributed towards a fragmented approach to workforce development.

More recently, the Ministry has commenced cross-Directorate planning work that will incorporate intellectual disability services. However, the National Forensic Capacity Plan has a longer-term focus, and it is critical that the specific requirements for services for people with an intellectual disability are not overlooked.

I do not consider that the actions the Ministry did take to address the capacity issue and associated problems during the period I have looked at were sufficient or timely. The Ministry did support the development of Capital & Coast DHB's ISUs, and these will undoubtedly see a significant improvement in the quality of life for some service users. However, the Ministry did not undertake adequate demand modelling to quantify the extent of unmet demand. In the absence of reliable information and analysis about how the Ministry intended to maintain and develop Framework services in the short, medium and long term, other DHBs were understandably reluctant to invest in the development of business cases for service expansion. It appears that the Ministry was slow to take any substantive action to address the need for additional capacity in the Auckland region, and to ensure regional hospital-level services were funded equitably for the services they were providing.

I have also found that the Ministry's monitoring function has been focused on crisis management. Rather than identifying potential systems solutions to areas of Framework underperformance and outcomes for individual service users, the Ministry appeared to be operating in crisis mode, focused on attempting to resolve matters escalated by FCS(ID), relating to individual service users. I consider that this limited the Ministry's ability to understand and respond to systemic issues. In particular, the evidence before me suggests that the Ministry did not collect information to enable a collective and comprehensive understanding of service delivery or operational issues. Reporting on service delivery, processes and outcomes was not consistent. Information about the use of seclusion and restraint was incomplete. There was no system in place to measure and track unmet demand. In addition, the Ministry's systems for reviewing the information it did collect—information that could be used to guide service development—were too often ad hoc at best. This included information about both the operation of the Framework and the implications of Framework issues for individual service users. There was no process for considering information about the care and rehabilitation of service users whose needs were not fully anticipated when the Framework was established.

The operational issues that I have identified require consideration from a national perspective, and would benefit from being analysed and integrated into the Ministry's ongoing planning work. The planning and monitoring strands of the Ministry's management processes need to be more interconnected.

In terms of providing free and frank advice, I am not satisfied that the Director-General was provided with good quality, timely advice about the Framework. The lack of written advice provided between 2015 and 2017 makes it difficult to ascertain the extent to which the then Director-General was informed about the escalating capacity pressure and associated problems. While written advice was provided from 2018, in my view there was a lack of clear and practical advice about short-term options to address the capacity issue, and insufficient attention was paid to developing medium- to long-term options.

In respect of advice provided to the Minister, it appears that this was compromised by the Ministry's limited analysis and review of the capacity issue. I do not consider the briefings provided to the Minister were sufficient and in accordance with the 'no surprises' principle. Successive Ministers were not fully apprised of the implications of the Framework issues or provided with clear information about the options for dealing with those issues. The Ministry's briefings and advice to

the Minister did not adequately convey the extent to which the Ministry was unable to deliver on its responsibilities, and had the effect of downplaying the weakness of Framework performance and the Ministry's ability to manage the situation over the period of my investigation. In short, I consider the Ministry omitted to develop good quality and timely advice about Framework performance, and did not adequately highlight the urgency of the issues to the Director-General or Minister.

It appears that from late 2020, the Ministry made more concerted efforts to recalibrate its response to the Framework capacity crisis, and as a result more effective options and actions may eventuate. For example, the Ministry's ongoing planning work was extended to include community-level services. In particular, the Ministry commenced working directly with these providers to address urgent issues affecting service provision and bed availability. In addition, I am advised that the Ministry has started developing an investment plan to address the wider capacity issues, although precise details of this have yet to emerge. It seems that the Ministry may now be taking more substantial steps towards responding to the ongoing crisis.

In order for the ongoing work to succeed, the Ministry must develop a comprehensive and agreed plan regarding all aspects of service delivery, from which the resources to support the Framework can be quantified and requested. The Ministry must fully engage with the workforce issues and ensure that the cross-Directorate planning work does not lose sight of the specific requirements for services for people with an intellectual disability. The formulation of a comprehensive Framework national service delivery plan, informed by robust data and with input from relevant stakeholders, and a clear strategy to mitigate the capacity crisis, is likely to greatly assist in improving Framework services.

My opinion

In my opinion, the Ministry's oversight of the Framework during the period of my investigation was not adequate and, as such, it did not meet its stewardship accountabilities. I am not satisfied that the Ministry took all reasonable steps to ensure the Framework operated so as to maximise the opportunity for service users to live balanced, satisfying lives, and with the greatest possible level of independence. The Ministry's performance in this regard appears to be inconsistent with Disability Convention obligations to protect and promote the rights of persons with disabilities, and to prevent breaches of their rights.

My specific concerns, in the context of the Ministry's responsibilities as kaitiaki of the health and disability system, are summarised below. Taken together, they are the basis for my opinion that the Ministry has acted unreasonably.

Planning

- The Ministry did not have or develop a cohesive, overarching plan to guide the effective delivery of Framework services and ensure that the rights of all Framework service users were upheld.
- The Ministry should have commenced collaborative planning with DHBs about the Framework at an earlier juncture.
- The Ministry did not develop a timely, targeted plan to mitigate the acute capacity crisis and ensure the statutory requirements of the IDCCR Act were able to be met.

- The Ministry did not adequately incorporate community-level services into planning for the Framework.
- The Ministry did not adequately include workforce issues in its ongoing Framework planning.

Actions taken

- The Ministry did not develop or implement adequate measures to address the acute capacity issue.
- The Ministry did not adequately support the ongoing needs of the Framework. For example, it did not:
  - adequately progress demand modelling;
  - proactively address the need for additional capacity in the Auckland region; or
  - take timely steps to ensure that regional hospital-level services were funded equitably.

Monitoring and reviewing

- The Ministry's systems for monitoring and reviewing the overall operation of the Framework were not adequate.
- The information collected by the Ministry about Framework performance did not enable a collective and comprehensive understanding of service delivery or operational issues. In particular:
  - there was no consistent reporting across the Framework concerning service delivery, processes, or outcomes;
  - the data collected on seclusion and restraint did not enable the Ministry to track seclusion and restraint trends on an ongoing basis, or readily allow for the disaggregation of data about Framework service users; and
  - there was no process in place to measure unmet capacity demand.
- The Ministry did not have a system or process for reviewing information it collected about:
  - service delivery issues and outcomes for service users;
  - the care and rehabilitation of service users whose needs were not fully anticipated when the Framework was established;
  - Framework operational processes, including service user placement, transition and absconding incidents; and
  - the use of seclusion and restraint in Framework services.

Advice provided

- The Director-General was not provided with good quality and timely advice about the Framework, including the immediate capacity issue and the longer-term challenges.
- The briefings provided to the Minister did not fully adhere to the 'no surprises' principle in terms of the frequency and significance of the issues.
- The Ministry's briefings and advice to the Minister did not fully convey the extent to which the Ministry was unable to deliver on its responsibilities and gave the impression that the longer-term solutions provided adequate mitigation.

Ministry update: current work programme for the Framework

In its response to my provisional opinion, the Ministry outlined key components of the work programme it has established for improving services under the Framework, as follows.

1 *The Individualised Service Units have been commissioned and are due to open later this year. The opening of this service will have a significant impact on the operational capacity of the [Framework] and will support individuals who are currently occupying more than one placement (bed) — thereby releasing beds for other people.*

2 *Five additional hospital level forensic beds have been purchased at Waitematā DHB. These have been open since 14 April 2021.*

3 *Funding has been increased by $1.7 million a year for hospital level services to align the various DHB rates nationally. This will contribute to the financial sustainability of these services and support the provision of a nationally consistent model of care.*

4 *The Ministry continues to work with DHBs on the development and implementation of the national model of care. The model of care reflects international best practice, as a comprehensive approach to the provision of care and rehabilitation for offenders with an intellectual disability, and who have high and complex behavioural needs.*

5 *The Ministry has developed a forensic capacity plan and national asset management planning to support future budget bids and a robust capital plan. The forensic capacity plan provides a clear indication of future need for hospital level services under the [Framework].*

6 *The Ministry has met with Regional Intellectual Disability Supported Accommodation Services (RIDSAS) providers to identify and address issues affecting service provision with a range of investments. This work will be supported by additional resource. The investments (amounting to $5 million p.a.) include:*

   a *Increasing the funding rate for RIDSAS providers.*

   b *Funding additional RIDSAS beds in the Auckland and Wellington regions to support increased capacity.*

   c *Providing additional funding to assist with the enhancement of secure services nationally.*

The Ministry commented further:

> *The Ministry is likely to be able to fund much of this work from within the annual appropriations that are available to it. The Ministry will seek additional funding through the annual Budget process if it is required to support the ongoing development of the [Framework].*
>
> *In addition, the Disability Directorate is seeking to improve the way it commissions services generally, including residential services. A central aspect of this work is improving the early support for people from the time that a disability emerges. This increases the chance that people will live a good life that is connected to the community and, over time, reduces the risk that they will require services under the [Framework].*
>
> *The Ministry will also be developing a strategic plan specifically for the [Framework] to support the ongoing maintenance and development of the [Framework].*
>
> *In addition, advice on the implementation plan and pathway for the transformation of the disability support system based on the Enabling Good Lives vision and principles will also go to Ministers later this year. That advice, and any decisions that Cabinet makes in response to it, may also have some implications for the [Framework].*

Recommendations

In making my recommendations, I have taken account of further work undertaken since the end of the period under investigation as outlined above.

Pursuant to section 22(3) of the Ombudsmen Act 1975, I recommend that the Ministry take the following steps to fulfil its stewardship obligations of the system:

1 The Ministry as a priority:

- a ensures that service users referred by the courts are accommodated in appropriate facilities;
- b develops a comprehensive five-year strategic plan for the High and Complex Framework, in collaboration with DHBs and NGO providers, that:
  - i identifies short-, medium- and long-term goals and objectives;
  - ii clearly outlines roles and responsibilities;
  - iii ensures there are clear and transparent processes for Framework operations, including the interfaces between prison, hospital- and community-level services; and
  - iv defines intended outcomes in accordance with the Disability Convention;
- c monitors and reviews the new strategic plan;
- d ensures that contractual arrangements are up to date and consistent with the new strategic plan; and
- e reviews the processes for data collection, analysis, and review about the use of seclusion and restraint in Framework services, bearing in mind Article 31 of the Disability Convention.

2 The Ministry ensures that:

a providers of community-level services are complying with the security requirements as set out in the Secure Services Matrix; and

b reporting on the Framework is consistent, structured and enables the Ministry to:

i receive timely feedback on any service delivery and operational issues; and

ii monitor the progress of service users with intensive support needs, and of women and youth.

3 Additionally, the Ministry ensures that the Minister is kept regularly updated on any significant issues as they arise, and on progress to improve Framework performance.

4 The Ministry reports to me on the progress of these recommendations on a quarterly basis for 12 months following the first report, due on 24 September 2021, and subsequently at mutually agreed intervals.

Appendix 1. Glossary

Term	Definition
Autism	Neurodevelopmental presentations that affect the way people think, feel, interact with others, and experience their environment. It exists on a 'spectrum', meaning traits manifest differently and to varying degrees in each person. There is no strong evidence linking autism with the risk of offending. However, people with autism commonly experience challenges with social communication and interaction, repetitive and restrictive behaviour, sensory sensitivities, anxiety, and highly focused interests or hobbies.
Civil clients	Term used by the Ministry to describe service users under the High and Complex Framework who are not subject to a IDCCR Act compulsory care order.
Capacity funding	Funding arrangement where the Ministry purchases a fixed number of beds and associated services from a provider (regardless of whether these beds are always in use).
Capital expenditure	Funds spent on purchasing or upgrading buildings, land, and major equipment.
Care and rehabilitation plan	A legal document prepared by a care manager. Among other things, care and rehabilitation plans identify care recipients' personal strengths, aspirations, risks, and support needs.[193]
Care manager	A health professional designated under the IDCCR Act who is responsible for overseeing the delivery of a care recipient's day-to-day care and support.[194]
Compulsory care	Where a care recipient must stay in a hospital or community-based facility and engage in personalised care and rehabilitation.
Compulsory care coordinator	A health professional appointed under the IDCCR Act who operates within a particular geographic region, and is primarily responsible for coordinating court-related matters.[195]

193 See the IDCCR Act, s 25(1)(a)–(h) for a full list of matters that must be identified in a care and rehabilitation plan.

194 Designated under the IDCCR Act, s 141. Section 47(1) notes that the compulsory care of a care recipient is entrusted to a care manager designated by the coordinator.

195 Appointed pursuant to the IDCCR Act, s 140.

Compulsory care order	A court direction under the CP(MIP) Act that determines the length of time a person must spend as a care recipient, and the level of security the person is subject to in a hospital or community-based facility.
Care recipient	A person with an intellectual disability who is made subject to a compulsory care order after being charged with or convicted of a serious offence.
Care recipient no longer subject to the criminal justice system	One of two types of care recipient. A person who is subject to a compulsory care order but is not (or is no longer) open to being imprisoned.[196]
Community Liaison Team	Teams operating out of the RIDSS who provide services for service users under the High and Complex Framework who are living in the community (or transitioning there).
Criminal Procedure (Mentally Impaired Persons) Act (CP(MIP) Act)	Statute providing the courts with a range of options for the assessment, detention, and care of people with intellectual disabilities charged with or convicted of a serious offence.
District Inspector	A lawyer appointed by the Director-General of Health under both the Mental Health Act and the IDCCR Act who provides an *'independent monitoring function to ensure that people subject to the [Acts] have their legal rights respected and upheld'*.[197]
Disability Directorate	Branch of the Ministry responsible for planning, purchasing and overseeing services accessed by the disabled community (established October 2018).
Disability Support Services (DSS)	A former Ministry group responsible for commissioning and monitoring services that support disabled people and their families (disestablished late 2019).
Fee for service funding	Funding arrangement where the Ministry purchases additional beds and associated services from a provider once their capacity-funded beds are all in use.
Forensic Coordination Service (Intellectual Disability) (FCS(ID))	National agency that determines a person's eligibility for services under the High and Complex Framework, employs compulsory care coordinators, coordinates care recipient referrals and manages placements in hospital or community facilities.

196 IDCCR Act, s 6(1).

197 Ministry of Health *A Guide to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (August 2004) at 6.

Health Quality and Safety Commission (HQSC)	The Commission is *'responsible for assisting providers across the whole health and disability sector – private and public – to improve service safety and quality and therefore outcomes for all who use these services in New Zealand'*.[198]
High and Complex Framework (the Framework)	Ministry-funded services that support a small number of eligible people with an intellectual disability whose support needs are assessed as being 'high and complex'.
Intellectual Disability Compulsory Care and Rehabilitation Act (IDCCR Act)	Statute that provides for the compulsory care and rehabilitation of people with intellectual disabilities charged with or convicted of a serious offence.
Mental Health (Compulsory Assessment and Treatment) Act (Mental Health Act)	Statute setting out the circumstances and conditions required for people to undergo compulsory mental health assessment and treatment.
Model of Care	A care and rehabilitation planning framework for health professionals working with High and Complex Framework service users.
National Intellectual Disability Care Agency (NIDCA)	Predecessor of FCS(ID).
National Intellectual Disability Secure Services (NIDSS)	Hospital-based beds and associated services for inter-regional High and Complex Framework service users. (Because NIDSS also provide for service users within their own region, they are categorised as NIDSS/RIDSS).
National Youth Intellectual Disability Secure Service	Hospital-based service for inter-regional High and Complex Framework service users aged under 18.
Operational expenditure	Funds spent on the ongoing expenses needed to run an organisation day to day.
Positive Behaviour Support (PBS)	A framework *'which aims to improve a person's quality of life and the quality of life of those around them'*.[199]
Regional Intellectual Disability Care Agency (RIDCA)	Predecessor of NIDCA.

198 Pursuant to the New Zealand Public Health and Disability Amendment Act 2010. Professor Alan Merry "Our role" (May 2017) Health Quality and Safety Commission New Zealand.

199 Healthcare NZ Limited "Explore Specialist Advice" (2018).

Regional Intellectual Disability Supervised Accommodation Services (RIDSAS)	Community-based residences providing secure or supervised accommodation and associated services to High and Complex Framework service users within a particular region.
Responsible clinician	An approved psychiatrist or other registered health professional who coordinates the treatment of a person subject to the Mental Health Act. A responsible clinician must be assigned to every person subject to that Act.
Regional Intellectual Disability Secure Services (RIDSS)	Hospital-based beds and associated services for High and Complex Framework service users within a particular region.
Service users	For the purposes of this report, 'service users' describes people with an intellectual disability who access Ministry-funded supports.
Special care recipient	A type of care recipient. A person who, due to the very serious nature of their offence, is subject to a longer compulsory care order and liable to (or serving) a term of imprisonment.[200]
Specialist Assessor	A health and disability professional (usually a psychologist or practising psychiatrist registered as a medical practitioner) who assesses whether a person has an intellectual disability under the IDCCR Act.
Step-down services	For the purposes of this report, 'step-down services' are DHB facilities providing beds and associated services designed to assist service users transitioning from the hospital-level secure care into the community.
Supernumerary funding	Funding arrangement where additional beds and associated services are provided in excess of capacity-funded or fee-for-service beds (person-specific).

200 IDCCR Act, s 6(2).

Appendix 2. Investigation methodology

In late 2018, I informed the Ministry of my intention to conduct this investigation. The investigation was formally notified on 22 January 2019.[201] I advised the Ministry's Chief Executive that I had commenced a self-initiated investigation under the Ombudsmen Act 1975. I provided the Terms of Reference, which set out the purpose, scope, investigation process, and report process.

I then wrote to the Chief Executives of the five DHBs providing hospital-level secure services for people with an intellectual disability, advising them of my intention to seek meetings with, and information about, some of the people under their care, as well as information about their services and facilities.

On 14 February 2019, I publicly announced my investigation.[202]

In the course of my investigation to date, I have obtained and reviewed a range of written information from the Ministry, including policies and guidance, correspondence, memoranda, planning documents, and review reports. Relevant Ministry staff were interviewed either in person, by video conference or by telephone.

I have also obtained from the Ministry information about a number of service users who had been brought to my attention during the scoping and early investigative phases, and whose experiences appeared to illustrate, at a very personal level, the matters I intended to examine.[203] These include the twelve people whose experiences are documented in my report. Each of them was provided with information about my investigation, and advised of my wish to talk about aspects of their lives in my report, in an anonymised manner.[204] Some of them were clearly interested in what I proposed, others less so. In each case, contact was also made with key family members/whānau or the person's legal representative where one had been appointed. In all cases, the service users themselves and/or their representatives have been supportive of my proposal.

Throughout 2019 and 2020, my staff undertook several visits to each of the five DHBs. Initial visits took place in February and April 2019, with my staff visiting the relevant facilities and meeting with key staff. There were three or four subsequent visits to each of the DHBs, in order to interview staff and to meet with the service users included in my case studies and, in some cases, with their whānau. Meetings were also arranged with other service users who are no longer accommodated in DHB secure services, and sometimes with their family/whānau. The DHBs also provided a range of written information, relating to their service users, services, and facilities.

In late 2020, I wrote to the Ministry and the DHBs, seeking some further final information and comments on matters I had identified as being the focus for my investigation.

201 As required by s 18(1) of the Ombudsmen Act. This investigation has been conducted pursuant to ss 13(1) and 13(3) of that Act.

202 Office of the Ombudsman "Chief Ombudsman commences two investigations into the Ministry of Health and its services for people with intellectual disabilities" (Media release, 14 February 2019). As outlined in this media release, at the same time, I announced a second investigation into the Ministry of Health, relating to the collection, use, and reporting of information about the deaths of people with intellectual disabilities who had been receiving full-time residential support. This investigation was formally notified on 26 October 2018, and concluded in June 2020. My final report was published in July 2020. See Chief Ombudsman Peter Boshier *Off the record* (Office of the Ombudsman, July 2020).

203 For this reason, the service users as a group do not necessarily constitute a representative sample in terms of gender, age, and ethnicity. They do, however, include male and female service users who range in age from 22 to 63 years, and are of European, Māori and Pacific ethnicities.

204 This included providing them with explanatory material in EasyRead.

Information was also obtained from a range of other agencies, organisations, and individuals, either in writing or through meetings or interviews. These stakeholders and interested parties include: Careerforce, District Inspectors, Forensic Coordination Service (Intellectual Disability), New Zealand Disability Support Network, providers of community support services, the Health and Disability Commissioner, the Health Quality and Safety Commission, the Nursing Council of New Zealand, People First, and Te Pou.

In addition, I have considered a range of relevant publicly available information. I have also reviewed international conventions, relevant legislation, and case law.

On 22 April 2021, I invited the Ministry to comment on my provisional opinion and proposed recommendations. On 29 April 2021, I invited a number of third party stakeholders to comment on relevant sections of my provisional opinion. I have considered all responses and reviewed and revised my opinion where necessary. My investigators also consulted again with the service users whose experiences I considered in the course of this investigation and their whānau.

Appendix 3. Extracts from the Disability Convention

Article 12

Equal recognition before the law

1 States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2 States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3 States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4 States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5 Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

Article 14

Liberty and security of person

1 States Parties shall ensure that persons with disabilities, on an equal basis with others:

   a Enjoy the right to liberty and security of person;

   b Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2 States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

Article 15

Freedom from torture or cruel, inhuman or degrading treatment or punishment

1 No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2 States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 17

Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Article 25

Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

a Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

b Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

c Provide these health services as close as possible to people's own communities, including in rural areas;

d Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

e Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

f Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 26

Habilitation and rehabilitation

1 States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

   a Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

   b Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2 States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3 States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Article 31

Statistics and data collection

1 States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:

   a Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;

   b Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.

2 The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.

3 States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.

Appendix 4. Extracts from United Nations Convention on the Rights of Children

Article 20

1 A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

2 States Parties shall in accordance with their national laws ensure alternative care for such a child.

3 Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 23

1 States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2 States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3 Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

4 States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 37(c)

States Parties shall ensure that:

c Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances...[205]

205 As outlined on page 27, New Zealand maintains some reservations in respect of UNCROC, including '*the right not to apply article 37 (c) in circumstances where the shortage of suitable facilities makes the mixing of juveniles and adults unavoidable; and further reserves the right not to apply article 37 (c) where the interests of other juveniles in an establishment require the removal of a particular juvenile offender or where mixing is considered to be of benefit to the persons concerned.*' Ministry of Justice "UN Convention on the Rights of the Child", above n 31.

Appendix 5. Other domestic legislation

The State Sector Act 1988 and the Public Service Act 2020

For most of the period I have looked at,[206] the general responsibilities of the public service, including the Ministry, are as set out in the State Sector Act 1988. On 7 August 2020, this was replaced by the Public Service Act 2020.

Section 32(1) of the State Sector Act sets out the principal responsibilities of a chief executive:

> The chief executive of a department or departmental agency is responsible to the appropriate Minister for—
>
> a the department's or departmental agency's carrying out the purpose of this Act; and
>
> b the department's or departmental agency's responsiveness on matters relating to the collective interests of government; and
>
> c the stewardship of the department or departmental agency, including of its medium- and long-term sustainability, organisational health, capability, and capacity to offer free and frank advice to successive governments; and
>
> d the stewardship of—
>
> i assets and liabilities on behalf of the Crown that are used by or relate to (as applicable) the department or departmental agency; and
>
> ii the legislation administered by the department or departmental agency; and
>
> e the performance of the functions and duties and the exercise of the powers of the chief executive or of the department or departmental agency (whether imposed by any enactment or by the policies of the Government); and
>
> f the tendering of free and frank advice to Ministers; and
>
> g the integrity and conduct of the employees for whom the chief executive is responsible; and
>
> h the efficient and economical delivery of the goods or services provided by the department or departmental agency and how effectively those goods or services contribute to the intended outcomes.

Similar stewardship obligations are contained in the Public Service Act.

Section 11 sets out the overall purpose:

> The public service supports constitutional and democratic government, enables both the current Government and successive governments to develop and implement their policies, delivers high-quality and efficient public services, supports the Government to pursue the long-term public interest, facilitates active citizenship, and acts in accordance with the law.

206 January 2015 to December 2020.

Section 12(1) sets out five public service principles:[207]

> In order to achieve the purpose in section 11, the public service principles are:
>
> *Politically neutral*
>
> a to act in a politically neutral manner; and
>
> *Free and frank advice*
>
> b when giving advice to Ministers, to do so in a free and frank manner; and
>
> *Merit-based appointments*
>
> c to make merit-based appointments (unless an exception applies under this Act); and
>
> *Open government*
>
> d to foster a culture of open government; and
>
> *Stewardship*
>
> e to proactively promote stewardship of the public service, including of—
>
> i its long-term capability and its people; and
>
> ii its institutional knowledge and information; and
>
> iii its systems and processes; and
>
> iv its assets; and
>
> v the legislation administered by agencies.

Section 52(1) sets out the general responsibilities of chief executives of departments and departmental agencies:[208]

> A chief executive of a department or departmental agency is responsible to the appropriate Minister for—
>
> a improving ways of working across public service agencies; and
>
> b their agency's responsiveness on matters relating to the collective interests of government; and
>
> c the operation of their agency, including in carrying out the purpose of the public service under section 11; and
>
> d supporting that Minister to act as a good steward of the public interest, including by—
>
> i maintaining public institutions, assets, and liabilities; and
>
> ii maintaining the currency of any legislation administered by their agency; and
>
> iii providing advice on the long-term implications of policies; and

207 Public Service Act 2020, s 12(1).

208 Public Service Act 2020, s 52(1).

e the performance of the functions and duties and the exercise of the powers of the chief executive or of their agency (whether those functions, duties, or powers are imposed or conferred by an enactment or by the policies of the Government); and

f giving advice to Ministers; and

g the integrity and conduct of the employees for whom the chief executive is responsible; and

h the efficient and economical delivery of the goods or services provided by the agency and how effectively those goods or services contribute to the intended outcomes.

The Health Act 1956 and the New Zealand Public Health and Disability Act 2000

The Health Act 1956 and the New Zealand Public Health and Disability Act 2000 (NZPHD Act) contain the primary legislative settings for the health and disability sector.

Under the Health Act, the Ministry is given the *'function of improving, promoting, and protecting public health'*.[209]

The purpose of the NZPHD Act is to provide for the public funding and provision of personal and public health services, as well as disability support services, in order to pursue a number of objectives.[210] These include *'the promotion of the inclusion and participation in society and independence of people with disabilities'* and *'the best care or support for those in need of services'*.[211] The objectives of the Act are to be pursued to the extent *'reasonably achievable within the funding provided'*.[212]

The NZPHD Act also establishes the current structure for the organisation of health and disability services and government funding. It provides that:

- the Minister of Health must determine a strategy for health services to provide the framework for the Government's overall direction of the health sector in improving the health of people and communities;[213] and
- the Minister for Disability Issues must determine a strategy for disability support services to provide the framework for the Government's overall direction of the disability sector in improving disability support services.[214]

209 Health Act 1956, s 3A.
210 NZPHD Act, s 3(1).
211 NZPHD Act, ss 3(1)(a)(ii) and (iii).
212 NZPHD Act, s 3(2).
213 NZPHD Act , s 8(1). See Appendix 6 for further information about the Health Strategy.
214 NZPHD Act, s 8(2). See Appendix 6 for further information about the Disability Strategy.

Appendix 6. Health Strategy and Disability Strategy

Health strategy

The current health strategy, *New Zealand Health Strategy: Future Direction (the Health Strategy)* sets the direction of health services for the 10 years from 2016 to 2026, with the overall aim of improving the health of people and communities.[215] It recognises people with intellectual disabilities as a high-needs population.

Disability strategy

The current disability strategy, *New Zealand Disability Strategy 2016–2026* (the Disability Strategy), is designed to guide the work of government agencies on disability issues for the 10 years from 2016, and is identified as the government's vehicle for meeting the Disability Convention obligations.[216] The vision of the Disability Strategy is for New Zealand to become a non-disabling society—

> *…a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.*

The Disability Strategy identifies as key to its implementation:

- three sets of principles—Te Tiriti o Waitangi (the Treaty of Waitangi), the Disability Convention, and ensuring disabled people are involved in decision-making that impacts them; and
- two approaches—investing in our whole lives (a long-term approach), and specific and mainstream services (a twin-track approach).

The primary vehicle for implementing the Disability Strategy is the *Disability Action Plan* (DAP):

- The 2014–2018 DAP set out 12 priorities. Priority 9 was about making government services more responsive to disabled people, which includes increasing access to health services and improving health outcomes for disabled people, with a specific focus on people with intellectual disabilities.[217]
- The 2019–2023 DAP was released in November 2019. It includes 25 work programmes, to be delivered by 14 agencies (including the Ministry of Health) and their partners.[218] Improving disabled people's access to quality healthcare and health outcomes is again identified as a priority.

215 Ministry of Health *New Zealand Health Strategy 2016* (18 April 2016).

216 Office for Disability Issues Te Tari Mō Ngā Take Hauātanga *New Zealand Disability Strategy 2016–2026* (November 2016) at 6.

217 Office for Disability Issues Te Tari Mō Ngā Take Hauātanga *Disability Action Plan 2014–2018: Update 2015* (December 2015) at 14–15.

218 Office for Disability Issues Te Tari Mō Ngā Take Hauātanga *Disability Action Plan 2019–2023* (November 2019) at 5.

Appendix 7. IDCCR Act and CP(MIP) Act

Historical and legal context

Prior to 1992, people with an intellectual disability who committed offences for which they could be imprisoned were detained in licensed institutions or psychiatric hospitals under mental health legislation. Courts directed people into psychiatric or institutional services if they were 'mentally disordered' for the purposes of the Mental Health Act 1969 and Criminal Justice Act 1985.[219] People with an intellectual disability were included in the definition of 'mentally disordered'. If a person was found to be unfit to stand trial due to their disability, they could be detained in a psychiatric hospital.[220]

From the 1980s, there was a rolling process of de-institutionalisation and legislative reform. The new Mental Health (Compulsory Assessment and Treatment) Act 1992 amended the definition of 'mental disorder' so that people could not be detained solely on the basis of intellectual disability. This was consistent with contemporary theories of 'normalisation', which emphasised that disabled people should not be treated differently from other people. However, the definition of 'mental disorder' is broad and may still cover people with an intellectual disability who have offended in certain circumstances, based on a wider assessment of their symptoms and risks.[221]

As a result of this legislative (and social) change, many people with an intellectual disability moved into the community. Although most successfully transitioned to residential facilities run by disability providers, there were some highly publicised cases of people with intellectual disability who committed serious offences and were imprisoned. This unanticipated legislative gap led to the drafting of the Intellectual Disability and Compulsory Care Bill 1999 and the Criminal Procedure (Mentally Impaired Persons) Bill 1999. Provisions relating to people with an intellectual disability who had not committed an offence were excluded after the select committee review process. This means that, today, people with an intellectual disability who are experiencing a temporary behavioural crisis (and have not offended) can only be lawfully detained if they meet mental health legislation criteria. Otherwise, the placement of any person into a secure environment depends on informed consent processes.

On 1 September 2004, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) and Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act) came into force.

Section 7 of the IDCCR Act defines the meaning of intellectual disability:

1 A person has an intellectual disability if the person has a permanent impairment that—

- a results in significantly sub-average general intelligence; and
- b results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
- c became apparent during the developmental period of the person.

219 Mental Health Act 1969, s 2 and pts 3-4. See also the Criminal Justice Act 1985, pt 7 (which replaced the Criminal Justice Act 1954).

220 A person was said to be 'under a disability' if they could not plead, understand legal proceedings, or communicate adequately with counsel to conduct a defence. Criminal Justice Act 1985, s 108.

221 Under s 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, mental disorder is defined as an *'abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition'* to such a degree that a person has a seriously diminished capacity to take care of themselves, or poses a serious danger to their own or others' health and safety.

2 Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.

3 For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed—

a as 70 or less; and

b with a confidence level of not less than 95%.

4 The skills referred to in subsection (1)(b) are—

a communication:

b self-care:

c home living:

d social skills:

e use of community services:

f self-direction:

g health and safety:

h reading, writing, and arithmetic:

i leisure and work.

5 For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.

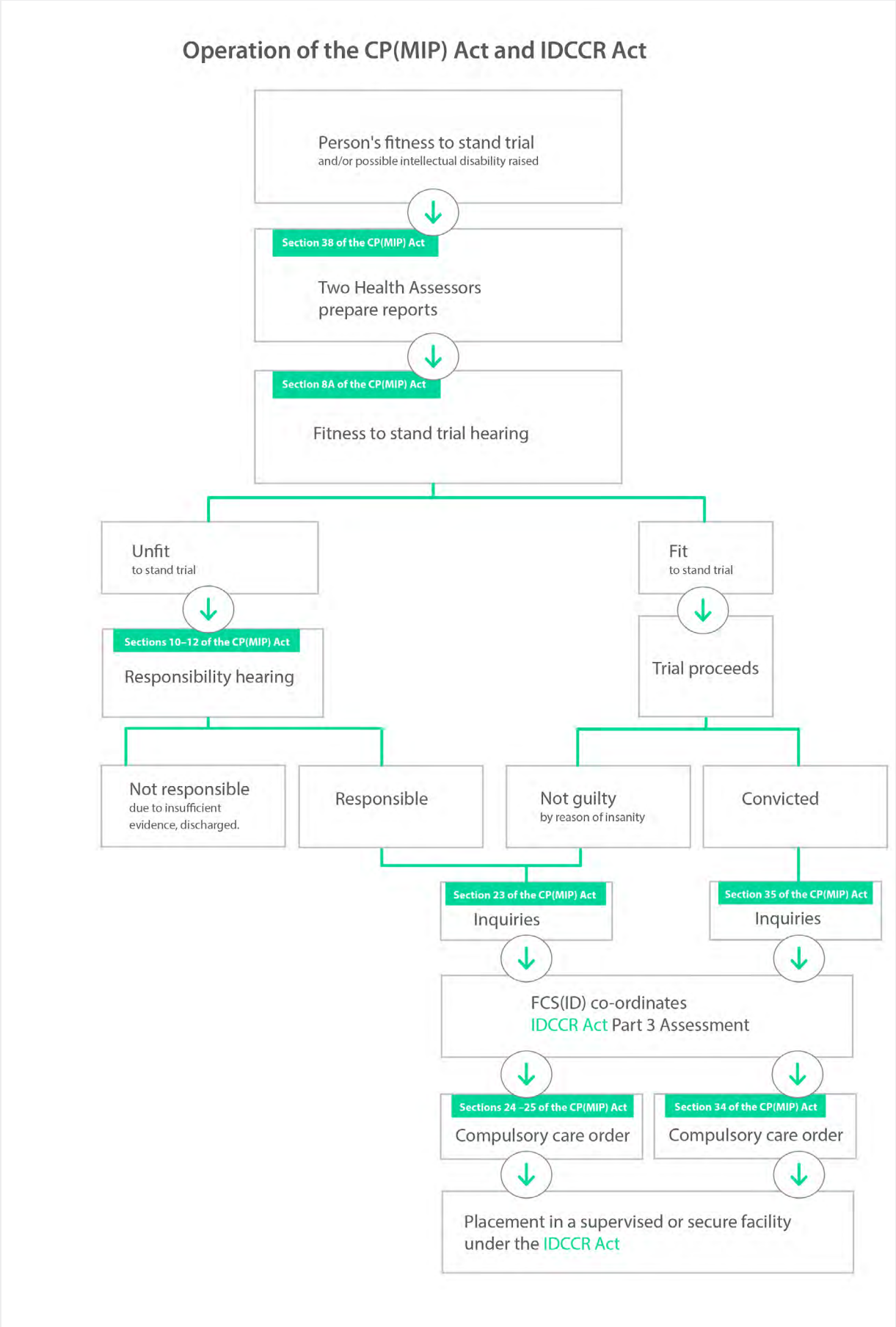


Figure 13: Operation of the CP(MIP)Act and IDCCR Act.

Appendix 8. National and Regional Intellectual Disability Secure Services (NIDSS/RIDSS)

The table below sets out the DHB and regions covered by each of the five DHBs providing regional and/or national secure services:

DHB	Region	Regional Secure Services	National Secure Services
Northland	Northern	Waitematā DHB	Waitematā DHB
Auckland			
Waitematā			
Counties Manukau			
Waikato	Midland	Waikato DHB	
Bay of Plenty			
Hawkes Bay			
Tairāwhiti			
Taranaki			
Lakes	Central	Capital & Coast	Capital & Coast DHB
Hutt Valley			
Capital & Coast			
MidCentral			
Wairarapa			
Whanganui			
Nelson-Marlborough	Upper South	Canterbury	
Canterbury			
South Canterbury			
West Coast			
Southern	Lower South	Southern	

Figure 14: Regional/national secure service areas by DHB.

The table below sets out in more detail the specific services provided by each of the five DHBs:

DHB	Type of service	Unit/Service	Location	Types of beds	Total number of beds[222]
Canterbury	Regional (Upper South)	Assessment Treatment and Rehabilitation Unit (AT&R)	Hillmorton, Christchurch	7 hospital-level secure[223] (3 capacity-funded and 4 fee-for-service) 1 assessment[224]	8
Capital & Coast	National and Regional (Central)	Haumietiketike Manawanui and Whakaruru	Kenepuru, Porirua	14 hospital-level secure (11 capacity-funded and 3 fee-for-service) 2 assessment 8 step-down[225]	24
Capital & Coast	National Youth Unit	Hikitea	Kenepuru, Porirua	8 hospital-level secure (6 capacity-funded and 2 fee-for-service)	8
Southern	Regional (Lower South)	Ward 10A Helensburgh Cottage	Wakari Hospital, Dunedin	6 secure hospital-level secure (4 capacity-funded and 2 fee-for-service) 1 assessment 4 step-down	11

222 As noted on page 40, the physical layout of some facilities means there are occasions when not all contracted beds can be made available where, for example, a service user's needs are such that they are unable to share living space.

223 Hospital-level secure beds are for service users in need of more intensive assessment and/or treatment than can be provided in a community setting. They can only be accessed with an appropriate legal mandate, such as a secure order under the IDCCR Act.

224 Assessment beds provide immediate access for people subject to court-ordered assessments, or for use in an emergency situation to respond to a crisis, or for an assessment period other than that directed by a court.

225 Step-down beds are generally used for service users preparing to transition out of hospital-level care.

DHB	Type of service	Unit/Service	Location	Types of beds	Total number of beds
Waikato	Regional (Midland)	Part of Puawai	Henry Rongamau Bennett Centre, Hamilton	2 secure hospital-level secure (capacity-funded) 1 assessment	3
Waitematā	National and Regional (Northern)	Pōhutukawa	Mason Clinic, Auckland	10 hospital-level secure (capacity-funded) 2 assessment	12

Figure 15: DHB Framework services.

As shown in Figure 16 below, the number of contracted national beds increased from 49 to 59 in 2010/2011, and from 59 to 66 in 2013/2014, with 6 additional beds contracted from Southern DHB and 11 from Capital & Coast DHB.[226] There have been no further increases since 2013/2014; however, the additional beds at Waitematā DHB are due to become available in 2021.

226 This does not include additional or 'supernumerary' beds, which the Ministry periodically purchases for specific service users who cannot be accommodated in a contracted bed.

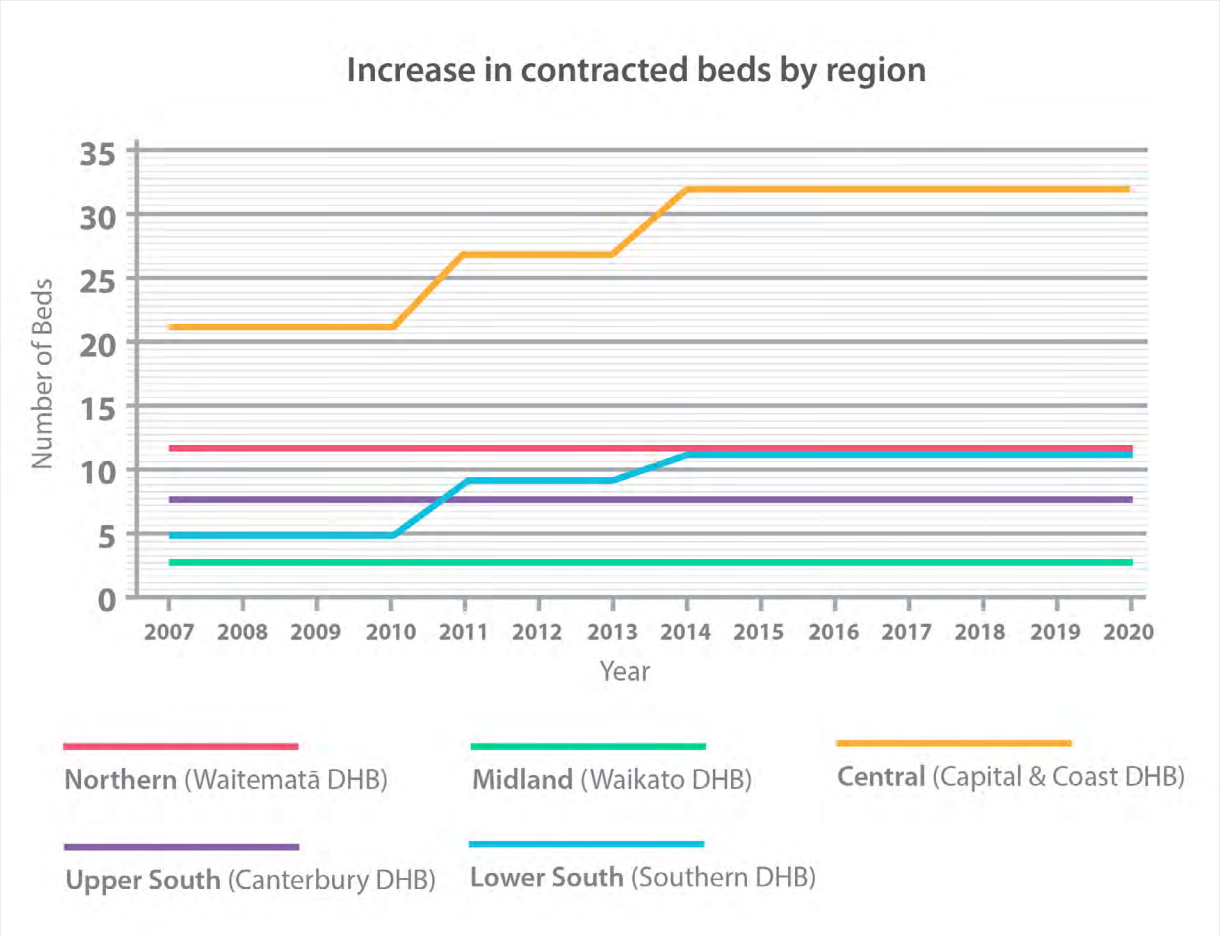


Figure 16: Increase in contracted beds by region.

Sample of concerns raised in the individual DHB Clinical-Fit-For-Purpose reports (September 2020):

DHB	Comment
Southern (Ward 10A)	*The layout and overall poor condition of the unit severely restrict the execution of the model of care in this ward, causing significant safety concerns…*
Canterbury (AT&R Unit)	*With the two flats being cordoned off, the unit has a serious lack of clinical support spaces to support its model of care...* *The environment is so compromised … that staffing is impacted, and as a consequence, most consumers require 1:1 nursing to keep everyone safe.*
Capital & Coast (Haumietiketike)	*In order to manage the myriad of challenges, it would be desirable for the unit to have more patient support spaces…* *Management of a patient who requires de-escalation is challenging, with one of the patients living in that space permanently.*
Waikato (Puna Maatai)	*The layout of the unit does not support the model of care … Existing space is not designed to be used flexibly.*
Waitematā (Pōhutukawa Unit)	*The layout of the unit is not flexible enough to support the accommodation of all groups who require inpatient care.*

Appendix 9. Health Workforce

In late 2009, Health Workforce New Zealand (Health Workforce) was created as a business unit within the Ministry to address concerns about the sustainability of the health workforce. There was a critical shortage of doctors and nurses at that time, and no single agency responsible for national workforce planning. In late 2018, a Ministry restructure resulted in the establishment of the Health Workforce Directorate. A statutory board (Health Workforce Advisory Board) was created to provide independent advice to the Ministry of Health.

Health Workforce funds a number of workforce centres, which undertake training and development in the area of mental health and disabilities, including Te Pou.

Te Pou is contracted by Health Workforce to support and develop the mental health, addiction, and disability workforce. It receives around $24 million in funding each year for the mental health and addictions workforce, and around $3 million annually for disability workforce development, which includes grants for training and workforce development initiatives. These grants are allocated in accordance with key priority areas agreed with the Ministry's Disability Directorate. In 2019, the strategic priorities for Te Pou for disabilities included Positive Behaviour Support, Autism, Whāia Te Ao Mārama (supporting Māori with disabilities), and 'High and Complex Needs'.[227]

Health Workforce has links with Careerforce in relation to the Kaiāwhina workforce, which includes non-regulated support workers for people with intellectual disabilities.[228] In partnership with Health Workforce, Careerforce developed the Kaiāwhina Workforce Action Plan (2015–2020).[229] This plan has recently been extended to cover the period from 2020–2025.

Health Workforce also looks at supply and demand data to ascertain gaps and workforce vulnerabilities, which may include training and qualification levels. It obtains data about the regulated professions primarily through the respective regulatory authorities and DHBs. Data about the nursing workforce, for example, is available through the Nursing Council of New Zealand (Nursing Council).[230] Health Workforce has limited access to educational data and there is a lack of quality data in relation to the non-regulated workforce, including support workers.

227 Te Pou stated that it was addressing the 'High and Complex Needs' priority area by facilitating the provision of Positive Behaviour Support (PBS) training through workforce development initiative funding. PBS training is delivered by Explore Specialist Advice and is based on training developed by the British Institute of Learning Disabilities.

228 Careerforce is an Industry Training Organisation for the health, wellbeing, social, and community sectors. It develops a variety of qualifications approved by the New Zealand Qualifications Authority (NZQA) based on industry need. Programmes that lead to the achievement of the qualification are then developed and delivered by Tertiary Education Organisations (including polytechnics, private training establishments, and Careerforce. In the case of industry training, the training itself is provided by employers through 'on-the-job' training.

229 The Action Plan sets out high-level Kaiāwhina workforce development goals. The actions not yet completed, including improving workforce data, have been rolled into the 2020–2025 Kaiāwhina Workforce Plan. The plan has five key priorities: building cultural capacity, connecting Kaiāwhina, ecosystem thinking, creating knowledge and data, and supplying and developing the workforce.

230 Under the Health Practitioner Competence Assurance Act 2003, the Nursing Council must ensure that practitioners are competent and fit to practice. The Nursing Council is responsible for the registration of enrolled nurses, registered nurses and nurse practitioners. It prescribes the qualifications and the education standards for nursing programmes in each scope of nursing practice. It works alongside NZQA to develop the qualifications framework. The Nursing Council also accredits and monitors the programmes delivered by nursing education providers.

Figure 17 below shows some of Health Workforce's key sector relationships.

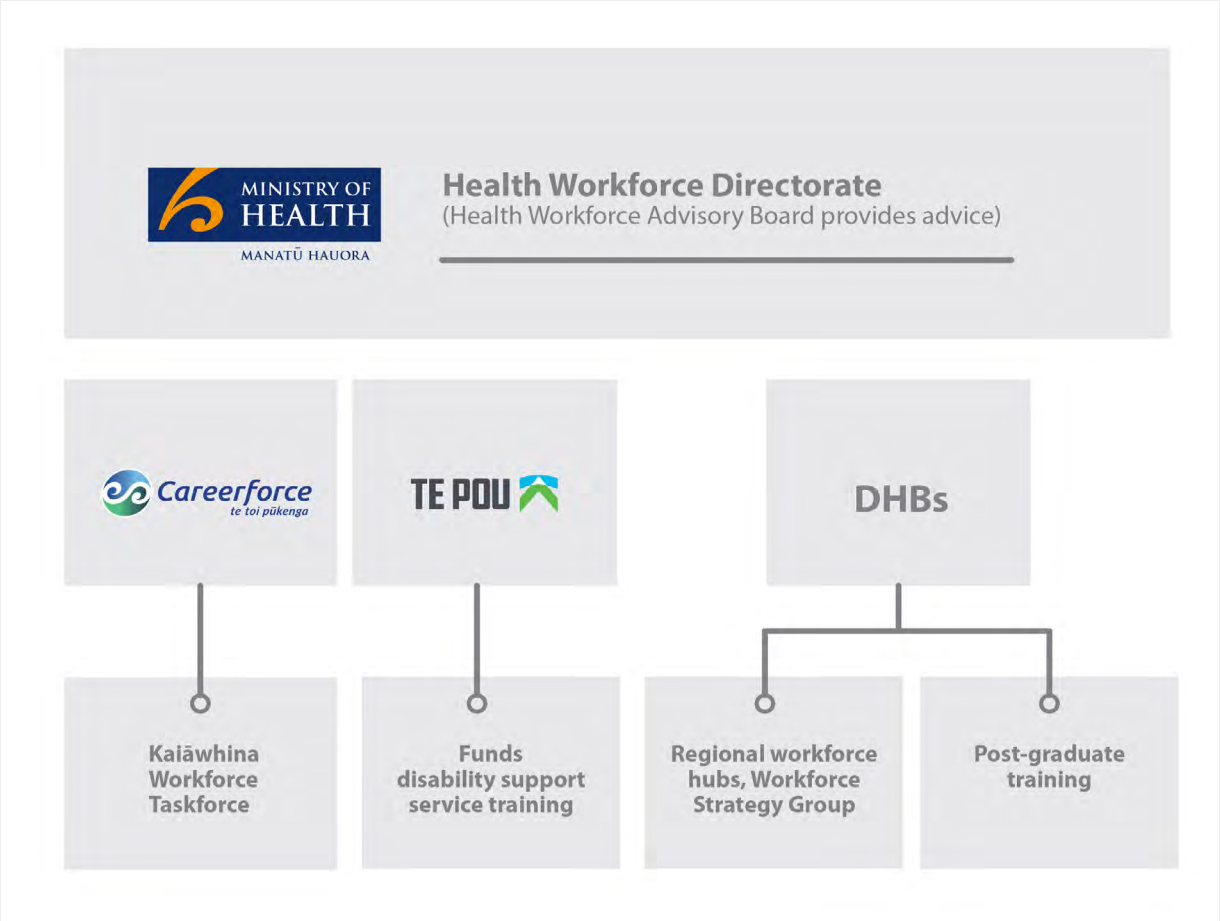


Figure 17: Relevant Health Workforce partnerships as at January 2020.

Health Workforce staff told my investigators that, as a new directorate, there had been an ongoing process of defining roles and setting up systems. They intend to take a 'whole of system whole of health workforce' approach, and focus beyond clinical and DHB staff. Health Workforce is developing a data strategy and is in the process of identifying the gaps in its health and disability data sets.

Health Workforce staff stated that part of the complexity of ensuring the sustainability of the health workforce is that no one agency holds all levers of control. Health Workforce does not fully 'own the delivery' of workforce plans. For example, developing a core competency framework for intellectual disability nursing would require buy-in from DHBs, the Nursing Council of New Zealand, education providers, and the New Zealand Qualifications Authority (NZQA).[231] Health Workforce advised me that although it could facilitate and influence the process, it had limited control or authority with regards to specific training initiatives. In terms of the support workers, training and competencies lie with Careerforce and the disability providers. The development of an agreed career pathway would be an employer-led process. Professional development, staff wellbeing, and staff retention are also generally employer responsibilities.

231 NZQA and the Tertiary Education Commission (TEC) are responsible for providing qualification frameworks. TEC also funds tertiary education providers.

Health Workforce also confirmed that it has no specific work programmes focusing on the intellectual disabilities workforce, and has not been directly involved in the Framework Project workforce sub-group. The Health Workforce training budget is largely directed at clinical nursing training, which means that support worker training is not funded to the same level as other professions. Training is therefore usually a cost to the employer or the individual. However, funding for disability workforce development via Te Pou, is available for the regulated and non-regulated workforce.

Health Workforce acknowledged that staffing shortages in relation to the disability workforce (including forensic intellectual disability) are a longstanding issue.

Appendix 10. DHB hospital-level secure services

Southern DHB

Southern DHB provides hospital-level secure services at Ward 10A, Wakari Hospital, and Helensburgh Cottage.

Ward 10A has 12 beds, including 7 beds for service users needing hospital-level secure care. There are also three beds for people with an intellectual disability experiencing behavioural challenges, and four 'dual diagnosis' beds for people with an intellectual disability experiencing suspected mental distress who require admission for assessment and treatment. The dual diagnosis beds are not contracted by the Ministry and are funded from the DHB's mental health budget.[232]

Helensburgh Cottage is a self-contained, purpose-built step-down facility close to the main hospital building. Its primary function is to prepare service users for transition to community-based living. Daily household activities such as shopping and cooking enable staff to assess what support the person will require in the community.

Southern DHB has the oldest secure mental health and intellectual disability facilities in New Zealand. Ward 10A is a repurposed nurses' home, with bedrooms running off narrow corridors in the style of a dormitory. The buildings do not support contemporary specialist care, with several reviews having concluded that Ward 10A is not fit for purpose.[233] There are significant safety concerns due to the layout. In contrast, Helensburgh Cottage does not have these types of concerns. One District Inspector described it as an *'excellent facility'*. However, the presence of several long-term occupants has limited the ability of Southern DHB to use the facility to its full potential.

Southern DHB advised me that fundamental limitations arising from the original function of Ward 10A have never been satisfactorily resolved. Ward 10A is very solid, and the layout is constrained by the physical footprint of the building. These limitations are managed through ongoing training for staff, and procedures and processes to manage risk. The environment and service user mix in Ward 10A has contributed to a higher frequency of incidents than occurs in the forensic mental health wards. Southern DHB also stated that it has continued to identify and explore potential alterations, renovations, and improvements to Ward 10A, and that it would welcome the closer involvement and support of the Ministry in relation to infrastructure.[234]

When my staff visited in December 2019, they reported that Ward 10A had a tired and rundown appearance, and was very noisy. It lacks the cluster arrangement for bedrooms found in the two purpose-built facilities. Almost all Southern DHB staff who were interviewed spoke about the poor state and design of Ward 10A, as well as the negative impact these shortcomings have on service user care and rehabilitation. The narrowness of the main corridor and location of bedrooms limits the line of sight and creates safety risks.

232 Overall, there are 14 beds designated for people with an intellectual disability, within a 12-bed ward. If the ward is at maximum capacity, then any referral under the CP(MIP) Act/IDCCR Act would require Southern DHB to move one of the mental health service users.

233 For example, in January 2019 Southern DHB obtained a report from Sapere Research Group into the state of the facilities at Wakari Hospital. The report concluded that the facilities created safety risks for patients and staff, and had a negative effect on the care provided.

234 Letter to Chief Ombudsman (14 May 2021).

The lack of private space is a major issue, with communal areas being used for clinical purposes. Southern DHB staff believe that the use of restraint and seclusion would be reduced if they had a facility with a physical structure that better enabled service users to be separated. Staff also commented that the co-location of forensic and non-forensic service users in Ward 10A had become increasingly problematic over the last few years. These groups have different support and rehabilitation needs, and forensic service users may have more specific and individualised care needs.

Southern DHB provides a specialist service but does not have a discrete intellectual disability model of care. Southern DHB staff implement the Good Lives Model of Offender Rehabilitation that underpins the Care and Rehabilitation Plan, and uses the general 'Primary Nursing' model of care.[235] However, staff stated that the physical environment of Ward 10A and staff vacancies were barriers to delivering good support and care. Both Ward 10A and Helensburgh Cottage have had a high number of registered nurse vacancies on an ongoing basis.[236] Southern DHB caps the number of service users at nine, partly due to the level of staff vacancies. Southern DHB stated that most staff learnt their skills 'on the job'. Some staff have been recruited from overseas.

Figure 18: Bedroom at Wakari Hospital.

Figure 19: Lounge area at Wakari Hospital.

235 The Good Lives Model works on the assumption that offending results from problematic means of trying to obtain 'primary goods', and that a person's risk of reoffending is likely to significantly reduce if their strengths and capabilities improve.

For further information about the Primary Nursing model of care see: HealthStream "Understanding the Primary Nursing Care Model" (August 2019).

236 For example, in December 2019, there were around 5 (out of 20) RN vacancies and it was difficult to sustain core staffing ratios. The day shift should include 31 RNs, 21 enrolled nurses (ENs) and 1 mental health assistant. However, the ratios were 1 RN, 1 EN and 4 mental health assistants.

Canterbury DHB

Canterbury DHB's Intellectually Disabled Persons Health Service is a regional intellectual disability secure service located at Hillmorton Hospital. It covers the Nelson-Marlborough, Canterbury, West Coast, and South Canterbury DHB regions. Canterbury DHB's inpatient services for people with intellectual disabilities are the Assessment, Treatment & Rehabilitation Unit (AT&R Unit) and the Psychiatric Services for Adults with Intellectual Disabilities Unit (PSAID Unit).

Canterbury DHB has two contracts to provide regional intellectual disability services:

- a Regional Intellectual Disability Secure Services contract, under which the Ministry purchases four beds (including one assessment bed), and up to four fee-for-service beds; and
- an Assessment Treatment and Rehabilitation (AT&R) contract, under which the Ministry purchases seven beds for people with an intellectual disability who usually reside in the community but need a period of more intensive, hospital-level support.

The AT&R Unit building design shares similar features to Southern DHB's Ward 10A. It was adapted into a medium secure unit and does not have cluster areas where people can be accommodated separately. As with Ward 10A, it is widely regarded to be not fit for purpose.[237] The AT&R Unit has significant deficits in terms of physical security and therapeutic spaces. The configuration of the unit increases the risk of incidents and assaults, and puts the safety of staff and patients at risk. In a briefing in December 2019, Canterbury DHB advised the Ministry that despite a series of modifications, the building remained unfit for the provision of a secure intellectual disability service.

The AT&R Unit has been capped by Canterbury DHB at six beds for several years. This is a result of concerns about safety, inpatient complexity and mix, staffing issues, and an internal modification made to the unit in late 2017 in order to create a separate space for one service user with high support needs. The Annex created a better therapeutic environment for that person but reduced the space available within the main part of the unit.[238] This is particularly problematic when service users who do not mix well are admitted.

In September 2019, the AT&R Unit's occupational therapy area was converted into a second self-contained area for another service user with complex support needs. The second annex does not impact on bed capacity, but further limits the space in the main part of the unit. AT&R service users now share the PSAID occupational therapy space. Canterbury DHB advised me that the second modification had reduced the levels of stress within the main unit.

Canterbury DHB staff stated that the layout of the AT&R Unit meant that it was difficult to support separately people who do not mix well. The narrow corridors and lack of separate space for therapy does not enable good quality care. There have been frequent incidents in the main corridor as everyone converges there, and staff often feel uncomfortable about their personal safety. The overstimulating environment of the unit can lead to an escalation in challenging behaviours. The location of the de-escalation area and seclusion room in the staffing area was an additional risk to be managed.

237 For example, in November 2017, Canterbury DHB obtained an independent review of the AT& R service to provide guidance to reduce risks in that service. It concluded that the AT&R Unit was inadequate and supported establishing the Annex.

238 The Annex includes a bedroom, lounge/living area, shower and separate toilet, and a separate entry/exit.

On occasion, service users under the Framework have been accommodated in the nearby forensic mental health unit, Te Whare Manaaki.[239] Canterbury DHB staff explained that mental health services use a 'recovery' model of care, whereas intellectual disability care has a behavioural focus. When my staff visited Hillmorton Hospital in March 2019, there were two intellectual disability service users residing in Te Whare Manaaki. Although staff from the intellectual disability service have remained involved in their clinical care, they regard the placement of these two people in a mental health unit to be less than ideal.

Like other DHBs, Canterbury DHB has struggled to recruit and retain experienced staff in New Zealand, including registered nurses, behavioural specialists, and clinical psychologists. The vacancy rate has fluctuated and, at times, it has been difficult to staff a full roster and there has been a heavy reliance on seconded or agency staff. Canterbury DHB has taken a behavioural model of care approach based on Applied Behaviour Analysis (ABA)[240] and the Good Lives Model for offenders.[241] However Canterbury DHB staff advised me that the constraints of the physical environment and difficulties in recruiting staff have been a barrier to fully implementing its model of care.

In 2019, Canterbury DHB began constructing an extension to the AT&R Unit to create four high-care 'pods' in order to provide a safer and more therapeutic environment for its service users with high and complex needs. Construction of the pods will involve the loss of two bedrooms in the main unit, but will increase the overall bed capacity by two. The pods are due to open around April 2021, when bed capacity will return to six. During the construction period, bed capacity was initially reduced to four. Canterbury DHB notified the Ministry that it was unable to accept any new admissions into the AT&R Unit.

Figure 20: Seclusion room at Hillmorton Hospital.

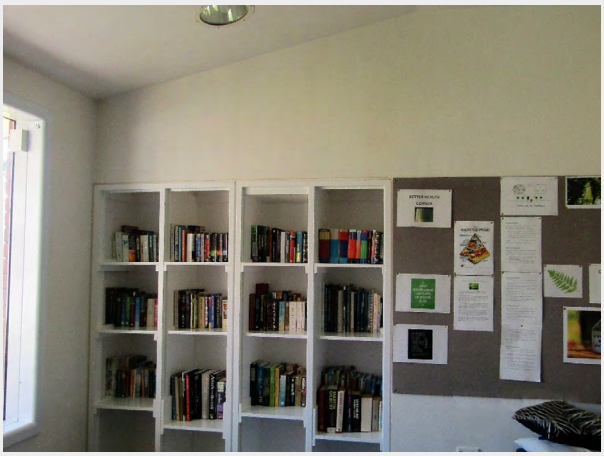


Figure 21: Library at Hillmorton Hospital.

239 Built in 1991, Te Whare Manaaki is a 15-bed medium secure unit providing inpatient assessment and treatment for people experiencing acute mental health distress.

240 ABA is a type of therapy that focuses on improving specific behaviours by assessing the relationship between the behaviour and the environment.

241 For more information on the Good Lives Model, see n 235.

Capital & Coast DHB

Capital & Coast DHB provides Regional and National Intellectual Disability Secure Services at the Haumietiketike Unit.[242] Capital & Coast DHB also provides the National Youth Intellectual Disability Secure Service at the Hikitia Unit. These facilities are both on the Kenepuru Hospital grounds. The Intellectual Disability Service is part of the DHB's Mental Health, Addictions and Intellectual Disability Service.[243]

Haumietiketike opened in 2004. It is capacity funded for 11 beds in total, including two assessment beds. Two four-bed 'step-down' cottages (Manawanui and Whakaruru) were added in 2006, to help prepare service users transitioning into the community.[244] In 2009, Te Aruhe opened at the rear of Haumietiketike, as a temporary National Youth Unit. In 2013, the eight-bed National Youth Unit Hikitia Te Wairua opened. It provides services for youth offenders with an intellectual disability, aged up to 18 years.[245] Capital & Coast DHB retained Te Aruhe as a back-up facility, using it primarily for female service users.[246]

Haumietiketike Unit caters for service users with a range of intellectual disabilities, challenging behaviours and other needs (including needs related to autism, foetal alcohol syndrome, and mental health distress). The design of the unit enables a degree of separation between service users. There are two four-bedroom clusters (clusters 1 and 2) and one three-bedroom cluster (cluster 3), with eleven bedrooms in total.[247] However, the complex support needs of several long-term service users in Haumietiketike were not fully anticipated in the building design. The facility's environmental limitations can make it difficult for some service users to have an acceptable quality of life and progress towards rehabilitation.[248] They may have limited independence within the facility, and little opportunity for social contact with others. Some people have spent prolonged lengths of time in restrictive or secluded environments, and they require more than one funded bed.

Hikitia is located in a building that also accommodates two youth mental health units (Nga Taiohi National Secure Youth Forensic Inpatient Mental Health Service and Rangatahi Regional Adolescent Inpatient Service). Like Haumietiketike, Hikitia provides a programme of therapy and activities based on the needs and interests of service users. This also includes education services, which are provided by the Central Regional Health School.

Hikitia has eight bedrooms and includes living areas, a dining room, recreation, and educational facilities. It has been extended to share additional rooms with Nga Taiohi, including two classrooms, a sensory room with adjustable coloured lights, an additional arts and crafts room, and a large gymnasium. In November 2019, my staff visited Hikitia and reported that the facility was modern, tidy, and well maintained. There were therapeutic and educational activities available.

242 In te ao Māori, Haumietiketike is the god that protects uncultivated food.

243 MHAIDS has three primary arms (mental health, forensic rehabilitation and intellectual disability) which are all funded differently, and operate across a three-DHB alliance involving Capital & Coast DHB, Hutt Valley DHB and Wairarapa DHB.

244 The two four-bedroom step-down cottages provide a less restrictive environment for service users who do not require the level of security provided by Haumietiketike.

245 Hikitia Te Wairua has six capacity-funded beds and two fee-for-service beds.

246 Te Aruhe is a Lockwood house located just behind Haumietiketike. Although Te Aruhe contains six beds, it can only be used for three service users at any one time, due to design and staffing issues.

247 Cluster 2 has recently been divided into two pods.

248 My report of 5 April 2018 on an unannounced inspection of Haumietiketike Unit under the Crimes of Torture Act 1989 stated:

Due to the nature of the needs of certain clients, some beds were permanently blocked as some clients were unable to rehabilitate in the way the Ministry of Health intended and require long-term, possibly lifelong care and support.

Capital & Coast DHB staff advised me that the impact of capacity issues on the daily routine of Haumietiketike became significant from early 2018. That pressure was compounded by the intensive support needs of some service users, and staff shortages. Movement around the unit was restricted and it was difficult to separate service users who did not mix well. Some individuals were prevented from accessing their rooms during the day, and spent their days 'milling around the unit'. The long-term occupation of the de-escalation area created ongoing challenges with managing service users who required use of that space.

Although there is a group of long-term staff members who know the service users well, Capital & Coast DHB has struggled to recruit and retain staff in the Haumietiketike Unit.[249] There are often difficulties filling the rosters with competent and experienced staff. Capital & Coast DHB run an ongoing overseas recruitment programme.

Building is underway to construct six Individualised Service Units (ISUs) adjacent to Haumietiketike, to provide individualised care for service users needing the highest level of support due to their mental health and/or an intellectual disability[250] This group of long-term service users is estimated to include around 5–10 people across the country. Capital & Coast DHB staff commented that the building design will result in a much less restrictive environment. The therapeutic environment will be much better, and the risks for staff and other service users will be reduced.

The ISUs were due to open in early 2020. However, the project was delayed for various reasons, including the need to undertake internal modifications to Haumietiketike. The delays led to an increase in construction costs of around $4 million, which required Capital & Coast DHB to go back to the Capital Investment Committee. Construction of the ISUs commenced in September 2020, and is now expected to be completed towards the end of 2021.

During their initial visit to Haumietiketike in early 2019, my staff were impressed by the quality of interactions between staff and service users. However, the facility felt 'tired', with limited natural light, and clearly did not suit the needs of several service users. The common areas were clean; however, some furniture was missing or damaged. Some of the bedrooms had posters, but there was limited personalisation. The sharp angles of the internal walls limited the line of sight within the units, including into the three clusters. Similar observations were made on a second visit in mid-2019.

Figure 22: Rainbow mural at Haumietiketike.

Figure 23: Room at Te Maara.

249 A February 2020 independent review into serious incidents in the Haumietiketike Unit noted that ongoing staffing shortages were a large part of the stress experienced by staff in the Intellectual Disability Service, despite the intensive recruitment drive.

250 In August 2018, Prime Minister Jacinda Ardern announced capital funding of $8 million for the ISUs, in order to provide individualised care for the most high-needs intellectual disability and mental health patients.

Waikato DHB

Waikato DHB provides the Midlands Regional Forensic Psychiatric Service, known as 'Puawai'. Inpatient services are provided in five forensic mental health wards at the Henry Rongomau Bennett Centre (HRBC). There is no dedicated intellectual disability service or facility at Waikato DHB. A new $100 million acute mental health facility is currently under construction at Waikato DHB. The new facility does not include forensic mental health services, and the precise configuration of beds has not yet been determined.

Waikato DHB does not specialise in the care and rehabilitation of people with an intellectual disability. The Ministry purchases three beds for Framework service users within the five forensic mental health wards, one for assessment and two for longer-term rehabilitation. This differs from other DHBs, where, as a general rule, service users whose needs relate primarily to an intellectual disability are placed in mental health units only when placement within a dedicated intellectual disability facility is unavailable.

Framework service users are generally placed in Puna Maatai (Ward 33) on admission. This is a 12-bed medium-secure acute admission and assessment ward, which has a two-bedroom 'pod' for people with an intellectual disability.[251] If the person is settled and progressing towards community placement, they may be moved to the less restrictive environments of Puna Awhi-rua (Ward 32) or Puna Poipoi (Ward 31).[252] Although Framework service users participate in ward rehabilitation programmes, there are no specific services or programmes for them.

Waikato DHB's HRBC has a forensic psychiatric model of care. There is no specialist model of care or programmes available for people with an intellectual disability. Not all staff are trained in the behavioural therapy that is a key component of care for people with intellectual disabilities.

Waikato DHB staff stated that their service users with an intellectual disability do not receive optimal care due to their placement in forensic mental health units. The two groups of service users have different support needs and often do not mix well, and this can trigger serious incidents. Interactions with unwell forensic mental health service users can result in intellectually disabled service users learning challenging behaviours. The high-stimulus, busy and noisy environment in forensic mental health wards does not generally suit people with intellectual disabilities, who often respond better to a quieter, calmer, and more predictable setting. Staff have comparatively little training in managing people with an intellectual disability, and there are very limited therapeutic options. Training in behavioural support is occasionally available, but not all staff have completed this. Waikato DHB reported fairly high staff turnover and some difficulties attracting nursing staff into the forensic mental health area.

251 While the pod has two bedrooms, one room may become unavailable if a person with high needs or a female service user is placed there. The location of the pod off the main corridor and across from the seclusion room frequently causes stress to the service users occupying those rooms, as they may be exposed to high levels of disruption and noise.

252 The two other forensic mental health wards (Puna Taunaki and Puna Whiti) are not secure, and are therefore unsuitable for Framework service users.

In 2020, Waikato DHB announced a 'system-wide review' of its Mental Health and Addictions Service to ensure that appropriate resources and services were available, in response to concerns about over-crowding.[253] Waikato DHB stated that intellectual disability services are not in scope, although the review will be looking at the continuum of care.

Figure 24: Room at Henry Rongomau Bennett Centre.

Figure 25: Corridor at Henry Rongomau Bennett Centre.

253 The extent of crowding in HRBC was the subject of comment in my March 2020 follow-up inspection report under the Crimes of Torture Act 1989. With three wards operating at 130 percent capacity, communal areas and offices were being used as temporary bedrooms. Intellectually disabled people were the target of bullying and assaults, and both groups were affected by mixing mental health and intellectual disability service users. For further information, see National Preventive Mechanisms *Report on unannounced follow up inspection of Wards 34, 35 and 36, Waikato Hospital, under the Crimes of Torture Act 1989* (Office of the Ombudsman, March 2020).

Waitematā DHB

Waitematā DHB is contracted by the Ministry to provide services to people with intellectual disabilities in the Northern region, which includes the areas covered by Northland DHB and the three Auckland DHBs—Auckland, Waitematā, and Counties Manukau.[254]

Inpatient intellectual disability services include ten beds for secure care and two assessment beds. The 12 beds are located in the Mason Clinic's Pōhutukawa Unit, which opened in 2006 as a medium-secure rehabilitation unit for adult service users with an intellectual disability.

Due to population growth, there is a general acceptance that more beds are required in the Northern region. The lack of step-down facilities is a gap in the continuum of care which makes it more difficult for service users to transition to the community. The desirability of more beds in the Northern region, including step-down cottages, is common ground between Waitematā DHB and the Ministry. However, the Ministry is constrained in its ability to purchase more beds for intellectual disability services, due to the lack of physical space. The Ministry has, however, recently purchased several additional beds in the adjacent mental health unit currently under construction.[255]

It is not uncommon for Framework service users to be cared for in other units at the Mason Clinic. For example, in July 2020, two female service users were housed in adjacent mental health units, as they could not be safely managed in the Pōhutukawa Unit. (These mental health units have designated areas for female service users.)

Waitematā DHB's workforce challenges are similar with those faced by other DHBs, and relate particularly to recruitment, training, and health and safety. Staff advised me they are concerned about the lack of external training that is available, including for the statutory role of care manager.[256] While there was in-house training, this was intermittent and not comparable to specialist training. Staff advised that the Pōhutukawa Unit generates more incidents and assaults than any other unit on the Mason Clinic site.[257] While Waitematā DHB has the advantage of being in the largest urban centre, the Pōhutukawa Unit is reliant on overseas recruitment for registered nurses with specialist intellectual disability training.

The Pōhutukawa Unit has a similar design to the Haumietiketike Unit, with the service user area on the ground floor and offices on the first floor. The main area includes four pods and a high-care area with two seclusion rooms, a lounge area, and a small enclosed courtyard. There is an activities/crafts room, a gym, an outdoor courtyard, a life skills kitchen and laundry, a dining room, and a 'Snoezelen' sensory room. A whānau room is located next to the unit.

The facility is well maintained, and was refurbished after it was identified as having the potential to become a leaky building. The main issues of concern relate to the layout of the facility. The pod or cluster arrangement and service user mix means it is not always possible to use all of the

254 Waitematā DHB intellectual disability services are part of the Regional Forensic Mental Health Service, often known as the Mason Clinic. The Mason Clinic is the largest forensic mental health service in New Zealand. Inpatient services include 114 mental health beds across seven units.

255 The Ministry agreed to purchase five capacity-funded beds. The beds will be in the 15-bed medium secure mental health unit, E Tū Tanekaha, which is currently under construction and expected to open in this year. As this will incorporate three beds currently purchased on a supernumerary basis, there will be a net increase of two beds. The beds are expected to be available until the existing Kahikatea Unit is decommissioned in around 4–5 years.

256 Care managers are health professionals designated under the IDCCR Act and appointed by care coordinators. In broad terms, Care managers are responsible for overseeing the delivery of a care recipient's day-to-day care and support.

257 For example, in February 2020 there were 50 incidents across the Mason Clinic the previous month, 30 of which were from the Pōhutukawa Unit.

bedrooms. For example, when my staff visited in February 2019, two service users were occupying two pods (four beds). At the time of two subsequent visits, one of these service users had moved out, but another service user, who also requires their own area, had moved in. This has meant that two beds have been unable to be used since 2017.

Waitematā DHB staff acknowledge that the Pōhutukawa Unit is not an appropriate environment for people who require long-term secure care. This complex group of people need facilities designed to support their individual needs and give them a higher quality of life. The District Inspectors responsible for the Pōhutukawa Unit stated:

> *The Mason Clinic does not provide an appropriate environment as a permanent home. There is a clear need for some kind of step-down accommodation to be available in the Auckland area, for people who reach a point where detention is primarily justified by risk rather than by the prospect of meaningful therapeutic intervention. These people may, for the rest of their lives, present a level of risk that makes ongoing detention proportionate and necessary in terms of the criteria applicable under the Act.*

Several staff advised me that, to meet the needs of the people they support, any new facility would be designed quite differently. A number of staff commented on how crowded and noisy the Pōhutukawa Unit can be, with up to ten service users and sometimes 19–20 staff present at one time. While high numbers of staff may be necessary to manage the risks and security, this can increase the risk of behavioural issues due to overstimulation. The noise is particularly problematic for people with autism. Staff also stated that the building design would be improved if it allowed for particular clusters to be separated off from the main unit.

Figure 26: Outside area at Pōhutukawa Unit.

Figure 27: Activities room at Pōhutukawa Unit.

Appendix 11. Seclusion and restraint

What do seclusion and restraint mean?

Restraint is *'the use of any intervention by a service provider that limits a consumer's normal freedom of movement'*.[258] Personal restraint occurs when a staff member uses their body to restrict a service user's movement. Physical restraint involves using equipment, devices or furniture to limit a person's ability to move, while environmental restraint is where a provider intentionally limits a person's access to their normal environment.[259]

Seclusion involves placing a person in a safe environment on their own, which they are unable to leave by themselves.[260] People cannot remain in seclusion for longer than is necessary to achieve the purpose of the seclusion event, and the practice should not be used for disciplinary or coercion purposes. In sum, people can be placed in seclusion in situations where their own or others' health and safety are endangered or compromised, or where it is 'necessary' for their care and treatment.[261]

The Ministry's guidelines for the use of seclusion under the IDCCR Act clarify that seclusion is a form of restraint, and note that *'any form of restraint is a serious intervention that requires a robust and clear rationale and oversight'*.[262]

Reducing the use of seclusion and restraint

The Ministry has supported training and strategies aimed at reducing the use of seclusion, including Safe Practice Effective Communication training, actions set out in the *Workforce Action Plan 2017–2021*, aims under the *Disability Action Plan 2019–2022* and principles included in the New Zealand Disability Strategy 2016–2026. A recent initiative is the Zero Seclusion Quality Improvement Project led by the Health Quality and Safety Commission in collaboration with Te Pou, a workforce development organisation funded by the Ministry.[263]

258 Standards New Zealand *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (NZS 8134.2:2008).

259 In addition, chemical restraint involves using medication to achieve service user compliance, but is disallowed under the Health and Disability Services Safe Restraint Practice Standards.

260 IDCCR Act, ss 60(1)(a)–(b).

261 See the IDCCR Act, s 60 and the Mental Health Act, s 71.

262 Ministry of Health A Guidance Document: The use of Seclusion under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (unpublished, August 2020) at 3. Prior to the release of these guidelines, disability services were informed by the Ministry's *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (February 2010).

263 See Appendix 9 for further information on the relationship between Te Pou and the Ministry.

The Zero Seclusion Improvement Project (2017–present)

Established in July 2017, the Zero Seclusion Project (the Project) is part of the Health Quality and Safety Commission's wider national mental health and addiction quality improvement programme. The Project focuses on eliminating the use of seclusion in acute and forensic inpatient mental health units. It provides a flexible model for DHBs to use and adapt according to their individual workforces, team culture, and environments. The Project began with a six-month co-design phase involving DHB project-groups, followed by a quality improvement phase which is ongoing.

A key part of the Project involves DHBs developing a suite of options aimed at reducing seclusion events. Change ideas include introducing sensory modulation, formulating techniques to de-escalate situations, and providing cultural support.[264] Feedback from service users and their families further informs these strategies.

In order to capture the outcomes, processes, and impacts of the Project, the Commission has developed a 'family of measures' for seclusion which DHBs report on.[265] DHBs observe their progress on the Commission's purpose-built interactive dashboard, which displays current seclusion data sourced from PRIMHD.

264 Health Quality and Safety Commission New Zealand *Annual Report 2018/19* (October 2019) at 25.

265 Outcome measures examine the number of DHB admissions who were secluded. Balance measures look at whether DHBs have seen a spike in events such as assaults or restraints while seclusion rates are decreasing. Process measures involve DHBs deciding which change ideas they will test, and how to measure them.

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