Residential Facility

A Report by the
Deputy Health and Disability Commissioner

(Cases 20HDC01848 and 22HDC03037)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. In 2014 Ms A and Ms B were residents at a facility that provided residential faith-based programmes to young women who were experiencing mental health challenges.

2. Both Ms A and Ms B complained about the operation of the programme, including the restrictions while they were residing in the house, intrusive practices regarding medical appointments, and counselling.

Findings

3. The Deputy Commissioner found that the facility failed to comply with legal standards in that it was not certified or audited, and it failed to retain health records. The facility breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) regarding each complainant.

4. The Deputy Commissioner found that the facility breached Right 7(7) of the Code in that it did not return Ms A's possessions and enable her to leave the facility when she withdrew her consent to its services.

5. The Deputy Commissioner found that Ms B should have been informed of her test results and given the opportunity to participate in the decision-making regarding her care, particularly whether hospital admission was indicated. The facility breached Right 6(1) of the Code.

6. The Deputy Commissioner criticised the facility for having operated a residential healthcare facility when staff did not understand the NZDS Restraint Standards, and did not have a policy on restraint and seclusion.

7. The Deputy Commissioner also criticised the facility for having failed to explain the roles of staff members Ms H and Ms I to the residents and potentially having incorrectly implied that they were registered nurses.

8. The Deputy Commissioner also criticised the facility for having coerced Ms A and Ms B into allowing staff to be present at medical consultations, and for having coerced Ms A into sharing her private information in order to receive counselling services.

9. The Deputy Commissioner criticised counsellor Ms J for having used the term 'soul ties' when providing counselling services.

10. The Deputy Commissioner criticised general practitioner Dr K for having failed to assess Ms B on 24 April, 30 April, and 1 May 2014 to ascertain whether it was appropriate for her to remain in the house. In addition, Dr K did not inform Ms B of her test results and discuss her management with her.

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Recommendations

11. The Deputy Commissioner recommended that the facility arrange for all staff to complete HDC's online learning Module 1 (How the Code of Rights improves health and disability services) and Module 3 (Complaints management and early resolution).

12. The Deputy Commissioner recommended that if at any point the facility intends to recommence its residential programme, it:

a) Arrange an inspection by HealthCERT before doing so, to determine whether it requires certification pursuant to the Health and Disability Services (Safety) Act 2001.

b) If, following any such inspection, it does require certification, it take all necessary steps to obtain that certification.

c) Set up processes to ensure that adequate records are maintained in accordance with the Health (Retention of Health Information) Regulations 1996.

d) Display a copy of the Code in a prominent location at any facility where it provides health services, and on its website.

e) Ensure that the qualifications of staff are made clear to consumers, including whether those with nursing training are registered nurses.

f) Ensure that staff accompany residents to medical appointments only with specific consent, which is recorded in each case, and that residents are free to refuse consent with no adverse consequences.

g) Develop policies regarding residents' participation in their own health care, including that all test results are provided to them.

h) Refresh its Resident Handbook with the Ngā Paerewa Health and Disability Services Standard (2021) in mind.

i) Set up processes to enable residents to withdraw their consent to services at any time and to leave the facility if they wish to do so.

j) Report on any further changes implemented as a result of this report.

13. The Deputy Commissioner recommended that Ms J provide an apology to Ms A for the criticisms contained in this report.

14. The Deputy Commissioner recommended that should Dr K return to practice, she complete HDC's three online learning modules for providers.

Complaint and investigation

15. The Health and Disability Commissioner (HDC) received complaints from Ms A and Ms B about the services provided by a residential facility. HDC received the complaint from Ms A

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in October 2020, and the complaint from Ms B in November 2022. The following issues were identified for investigation:

- *Whether the facility provided Ms A with an appropriate standard of care in 2014;*
- *Whether Ms A was coerced by staff into accepting treatment, or into staying at the residence;*
- *Whether Ms A was given appropriate information and provided informed consent to the care she received at the facility; and*
- *Whether the facility provided Ms B with an appropriate standard of care in 2014.*

16. This report is the opinion of Deputy Commissioner Dr Vanessa Caldwell and is made in accordance with the power delegated to her by the Commissioner.

17. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Ms B	Consumer/complainant
Ms C	Consumer's mother
Ms D	Executive director/provider
Ms E	Programme Manager/provider
Ms F	Counsellor/provider
Ms G	Counsellor/provider
Ms H	Provider
Ms I	Intake coordinator/provider
Ms J	Counsellor/provider
Residential facility	Provider
Dr K	Provider/general practitioner (GP)

18. Staff members Ms L and Ms M are also mentioned in this report.

19. Further information was received from:

Medical centre	Provider
DHB1[1]	Provider
DHB2[2]	Provider

20. Independent advice on the management of therapeutic communities was obtained from Mr Paul Hanton (Appendix A). Inhouse clinical advice was provided by GP Dr David Maplesden (Appendix B).

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand (now Health New Zealand|Te Whatu Ora (Health NZ)). DHB1 is now Health NZ.
[2] Now Health NZ.

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Structure of report

21. This opinion sets out the background that is applicable to both complaints. It then considers the details of each complaint separately and sets out the Deputy Commissioner's findings regarding each complaint.

Background: The facility

22. The facility is a charitable trust. The purpose and structure, as recorded on the Charities Register, includes 'Provides services (e.g. care/counselling)' in the health sector.

23. The facility told HDC that it is a non-profit organisation that helps young women who are experiencing mental health challenges. The facility stated that it provided residential[3] and community wellbeing programmes that were faith based, and also incorporated secular mental health treatment strategies and principles.[4] The stated aims of the facility include that it provides a place to heal and strengthen based on the Te Whare Tapa Wha model of health and that the organisation exists for the benefit of young women facing mental health challenges including anxiety, depression, disordered eating, self-harm and suicidal thinking. The facility told HDC that the programmes are voluntary and, although it employs qualified counsellors, it is not a medical treatment centre or facility.

24. The application for resource consent to operate the facility states that it would accommodate up to 12 girls. The facility told HDC that in practice it accommodated a maximum of eight residents but could accommodate 10 when there was a graduation and intake crossover. However, the facility was not certified with HealthCERT. Section 9 of the Health and Disability Services (Safety) Act 2001 states that providers of healthcare services (which may include residential mental health services of the kind provided by the facility[5]) must be certified. It is an offence to fail to comply. Section 27 states that, inter alia, in order to be certified, an auditing agency must have given the Director-General a copy of a recent audit report.

25. After referring Ms A's complaint about the facility to the Ministry of Health, HDC received information from the Ministry of Health stating that HealthCERT (the agency responsible for ensuring that facilities that require certification under the Health and Disability Services (Safety) Act 2001 are providing safe and reasonable levels of service) decided to carry out an inspection of the facility because 'they are providing a residential service to over five residents, which is the minimum required to apply for a certification'. However, HealthCERT later told HDC that it would not be carrying out the inspection as it had become aware that the facility was no longer providing residential services.

[3] Currently, the facility does not provide a residential programme.

[4] The facility stated that the programme is guided by Te Whare Tapa Whā model of health and incorporates both Cognitive and Dialectical Behavioural Therapy.

[5] Section 9 of the Health and Disability Services (Safety) Act 2001 states that providers of 'health care services of any kind' must be certified. Section 5 ('Health or disability services defined') includes mental health services, although mental health services are not specifically included in the definition of 'health care services of any kind' under section 4.

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26. In addition, at the relevant time, all residential mental health services, irrespective of funding sources, were required to comply with the New Zealand Health and Disability Sector Standards 2008 (NZHDSS).

27. The facility told HDC that it has not undertaken any audits apart from self-reviews because as opposed to a registered residential centre, it was a residential programme where participants are self-referred, with no government funding or contracts. It said that since 2010, its Programme Manager, Ms E, had made enquiries of organisations that would undertake an audit of its service, but because it is not a non-government organisation (NGO) and does not carry out any government contracts, the usual avenues of audit are unavailable to it.

28. The facility said that its attempts to arrange a Peer Review Group have been unsuccessful despite Ms E having made approaches to various organisations, but its financial accounts are audited annually.

29. The facility told HDC that its reflective practice and learning took several different forms, including daily handovers, practice reflection with the programme manager, and external supervision meetings. However, these practices were not recorded formally.

30. The facility told HDC that it did not retain residents' medication records. It had a policy titled 'Long-term Filing Guide', which instructed staff to keep medication charts and medical receipts for one year from a resident's exit from the transition phase of the programme, or their exit from the home if there was no transition phase. However, the Health (Retention of Health Information) Regulations 1996 requires providers (as defined in regulation 4) to retain health information for a period of 10 years beginning on the day after the date shown in the health information as the most recent date on which a provider provided services to that individual. It is an offence to fail to comply with the regulations.

House restrictions

31. The Resident Handbook (the Handbook) details most of the restrictions on, and requirements for, residents who entered the programme. The facility said that the Handbook was intended as an 'aid to communal living' rather than a 'rule book'. There were restrictions on communication, and Ms A told HDC that residents were told not to talk to anyone about either their reasons for entering the facility, or the treatment they received while there. In response to the provisional opinion, the facility stated that while it is correct that there were restrictions about communication with other residents, the Handbook does not state that residents were not to communicate with friends and family about their reasons for entering the home or the treatment they received. The facility said that communication with family and relevant support people was in fact encouraged.

32. No television was available at the facility, the newspaper was heavily redacted to the extent that largely it was unreadable, and staff selected the movies residents were allowed to watch. Mobile phones and wallets were taken from residents on arrival and kept in a safe. No glass or sharp items were allowed. No books that were not approved by staff

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were permitted. The facility said that it provided iPods for residents to use in the home, and residents were welcome to bring their own iPod, provided it did not have what the facility considered 'distracting functions'.

33. Residents were expected to dress modestly always, and shoes were always to be worn in the house. Only one resident was allowed in the bathroom at one time, and there was a strict 'no touch' policy whereby residents were not allowed to touch each other at all.

Mail

34. Mail received by residents had to be opened in the office in front of staff in case the sender had included anything 'unhelpful out in the home', and staff would remove any staples.

35. The Standards Agreement that residents signed before entering the programme advises residents that the reason mail is opened in front of staff is as an extra measure of accountability for residents and, if deemed necessary, staff would open incoming or outgoing mail, and any inappropriate correspondence might be denied.

Emails

36. The facility told HDC that residents used a central hub to send and receive emails via a single email address, but emails were not read by staff except to identify the intended recipient. It said that this was necessary because senders did not always specify the intended recipient in the subject line. The facility also told HDC that residents could reply to emails only on weekends because of the availability of the office computers, and residents were advised to delete emails after sending to prevent others from reading them.

37. The Staff Guide required staff to be present during internet usage to ensure that it was being used only 'for the purpose required and to support residents who might be tempted to access unhelpful material/websites'.

Telephone calls

38. As stated above, residents' cellphones were taken on arrival and kept in a safe. The Standards Agreement signed by residents states that residents were permitted to use the facility's telephone for three calls out on a Saturday, and to receive two calls on a Sunday, and calls from 'certain persons' could be restricted at the counsellor's discretion.

39. The Staff Guide instructs staff that residents could make and receive calls from the staff office during the allocated time. The Guide instructs staff to support new residents to use a phone card to call out and, once they were connected, to afford them privacy for the duration of the call. The Guide also instructs staff that residents must not be left in the office unsupervised due to the presence of sharps, medication, and confidential files. Phone logs were required to be completed, recording who had called and to whom a call had been made. A roster system was used for managing residents' access to the office phone.

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40. The facility told HDC that although the phones were located in the office, residents could make telephone calls in an outside area or in the counselling room for privacy. If the call needed to be made in the office (for example, because of wet weather), then a staff member would be present in the room because of the presence of confidential information and valuables in that area, but staff were not in the room to supervise calls.

Registered nurse staffing

41. Ms A and Ms B both told HDC that they were led to believe that staff members Ms H (Programme Assistant) and Ms I (Intake Coordinator) were registered nurses. The facility said that Ms H and Ms I were 'trained and qualified as registered nurses although not employed by us in this capacity'.

42. The facility told HDC that Ms H has nursing qualifications, was registered with the Nursing Council and had held an annual practising certificate (APC). The Nursing Council told HDC that in 2014 Ms I was registered with the Nursing Council but did not hold an APC.

43. Ms A told HDC:

> 'I trusted that they were telling me the truth about their training and because of that I trusted what they were asking me to do. It is a violation of the trust that we put into registered professionals by claiming to be something that they were not.'

44. Ms A said that she has trust in authority and professional figures and, when they stated their qualifications, such as being a registered nurse, she felt they had power and authority over her, and this also fed into her belief that she could be compelled to stay there.

45. In response to the provisional opinion, the facility stated that both Ms H and Ms I deny ever claiming to have a current nursing registration while employed at the facility. The facility said that Ms I responded that 'she cannot recall ever being questioned about her qualifications'. Ms H responded:

> 'If my previous work history came up in conversations, I would speak of having a background in nursing or that I previously worked as a nurse/used to be a nurse, but I no longer work in that role or are registered as a nurse, and that my role at [the facility] is as that of a Programme Assistant.'

Medical appointments

46. The facility told HDC that residents from outside the region were registered at the local medical centre so that they did not have to pay more expensive casual rates for medical attention. The facility said that the practice was chosen because it had an understanding of the facility's residential context and the needs of their client group. The facility also told HDC that it did not impose appointments on residents, and that '[s]taff transported a [r]esident and supported her in the [c]onsult depending on the [r]esident's consent'.

47. The Handbook advises residents that they would be enrolled at a local GP as specified by the facility. It also states:

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> 'A staff member will attend appointments to support you and provide any information that you may have forgotten. You may, at any time, request that the staff member leave the consultation. However, as staff are responsible for the administration of your medication it is important that they are consulted by the medical professional in attendance regarding medication requirements.'

48. In response to the provisional opinion, Dr K stated that in 2011 she was approached by the facility to be the GP for its residents. She said that this was not a formal arrangement, but she agreed to see its residents to provide GP services. Between November 2011 and September 2018, she saw many of the facility's residents for their medical needs. She was working part time, and took regular holidays, so the residents of the facility sometimes saw other doctors. She said that an accident and emergency clinic dealt with the after-hours care as Dr K had no obligation to be available 24/7, but she said that frequently she had contact with residents after hours.

49. The facility told HDC that the residents also signed the Medical and Property Release Agreement.[6] That agreement provides that the resident understood that they would be taken to a local medical facility if they became ill, and it includes an authority to release information and obtain services as the residential facility deemed appropriate. It does not refer to staff attending medical appointments with residents. The facility said that the staff protocol was to check verbally at each appointment that residents were comfortable with staff attending medical consultations and, if a resident requested privacy for the appointment, that was respected.

50. The Staff Guide also covers medical attention required by residents. It instructs staff to advise the GP that the resident is aware that she may ask the staff member to leave the consultation at any time as 'we operate on consent'.

51. The medical centre told HDC that at the first consultation, patients were accompanied by a staff member from the facility and, subsequently, whether the staff member was present or not was at the patient's request. The medical centre stated: 'Most times the staff member waits in the waiting room.

52. In response to the provisional opinion, the facility provided comment from Ms H, who said:

> 'My approach to all appointments was to check in with the resident prior regarding support in the appointment. If they had said yes, I would recheck during the appointment if they wanted me to remain if the medical professional wanted to complete physical investigations. At any stage the resident or medical professional communicated they did not want me there I would leave the room and reconnect at the end of the appointment regarding any plans e.g. being taken for blood tests, scripts being filled, follow up appointments or referrals were common outcomes to be facilitated.'

[6] Signed by Ms A on 16 April 2014.

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53. Both Ms A and Ms B told HDC that staff at the facility required them to be accompanied to medical appointments, which impaired their ability to speak freely to the doctor. In response to the provisional opinion, Ms B reiterated that her consent was never sought for staff to attend medical appointments.

54. Both Ms A and Ms B told HDC that staff at the facility accompanied them while they were at the hospital. In response, the facility said that staff stayed with Ms A for 45 minutes when she was taken to the emergency department (ED) until the Crisis Team arrived.

55. In reference to Ms B's hospital admission, the facility stated that its staff stayed for some time because of the seriousness of her condition, and they left once Ms B had settled.

Complaint: Ms A (20HDC01848)

Background

56. Ms A was in her late teens at the time of the events covered by this report. She had a history of severe depression and anxiety, obsessive compulsive disorder, insomnia, and an eating disorder. She also suffered symptoms of post-traumatic stress disorder, including periodic episodes of dissociation, and nightmares. Previously she had experienced sexual abuse.

57. In mid-2013, Ms A's mental health deteriorated, and she sought help for increasing suicidal thoughts and worsening of other symptoms. She was referred to a community mental health team, who assigned a social worker as her care manager. Ms A was also receiving group counselling through an organisation that supports people affected by sexual violence. During her appointments with the social worker, Ms A discussed her Christian faith and her church attendance. The social worker suggested that she might be interested in the facility.

58. Ms A has several concerns about her experiences at the facility, including (but not confined to) the restrictive nature of the programme, the nature of the counselling provided, being kept in seclusion, and being prevented from leaving. Ms A's complaint also details several other practices and incidents at the facility that she considers were inappropriate.[7]

Entry into the facility programme

59. Ms A told HDC that she was introduced to the facility by the social worker, who told her that she had former clients who had been through programmes at the facility with successful outcomes.

[7] For example, she described an incident where staff put their hands on her while praying and speaking in tongues and commanding demons to leave her body. The facility denied that this happened.

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60. The social worker recalls discussing the facility with Ms A. The social worker told HDC that she had heard of the facility from other clinicians as an option for women experiencing similar issues to Ms A's. The social worker also told HDC that she did not know of any other clients who had attended the facility.

61. The social worker's progress notes from her sessions with Ms A record their discussions. A note from 15 October 2013 records that the social worker 'introduced [Ms A] to … [a residential facility] and she expressed interest in attending'.

62. A note from 5 November 2013 records an appointment Ms A had with the social worker, in which Ms A stated that she would like to attend the facility. The note records, '[Ms A] is determined to do this,' and states that the social worker printed out the application form and asked Ms A's GP to fill out the medical section. The social worker also recorded:

> 'We agreed that [Ms A] doesn't need secondary MH [mental health] services in [the region] and just a GP will do … [Ms A] is aware that she'll now be [discharged] from [mental health services] and [the community mental health team].'

63. The then DHB2 'MH Partnership Plan Review' dated 8 November 2013 records Ms A's discharge from mental health services. It states:

> '[Ms A] has made the decision to not attend university next year in favour of attending the therapeutic [residential facility]. If accepted she's aware that this will be a challenging time, however she is willing to fully engage in the process in the hope of recovering from her trauma experiences.'

64. Ms A was discharged from DHB2 mental health services on 22 November 2013.

65. The facility commented on Ms A's statement to HDC that she had been told by her social worker that she was required to enter a programme at the facility if she did not want to be compelled to undergo treatment under the Mental Health Act. The facility told HDC that if it had been aware that a social worker had given Ms A such an ultimatum:

> 'This would have been a significant consideration with regards to the suitability of our programme for [Ms A] as we would not have supported her approach at all. Such a pressure on [Ms A] from the outset of [her] engagement with the facility would have affected our team's ability to develop an authentic and trusting relationship with [her].'

66. At the end of 2013 Ms A applied to enter the facility for a six-month residential programme.[8] She was accepted into the programme and entered the facility on 26 May 2014. Ms A completed the six-month programme and graduated from it in November 2014.

[8] The application is dated 5 October 2013, but the facility said that Ms A applied in March 2014.

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67. Ms A said that if she had known that the facility did not have properly qualified staff, she would not have gone to the programme. She stated that she had spiritual guidance and church support prior to attending the facility, and she left her studies and her home on the understanding that this was a professional and suitable facility and the only alternative to Mental Health Act orders. In response to the provisional opinion, the facility commented that during its intake interview with Ms A there was no mention that she believed the facility was the only alternative to Mental Health Act orders.

House restrictions

68. Before Ms A commenced the residential programme, she was provided with the Handbook. However, she said that she did not read it because it was very big. She stated that when she arrived, she was shocked by the number of restrictions imposed on residents in the house.

69. In response to the provisional opinion, the facility stated that Ms I's intake report dated 12 May 2014 reports:

> '[Ms A] has received and read through the resident's handbook and the nutrition questionnaire and has completed the questionnaire which she will post away also. [Ms A] mentioned that there is a lot to process from the handbook but that it all seemed fair and self-explanatory.'

70. Ms A was also provided with other documents detailing what was expected of residents, including an orientation document, the Standards Agreement (which Ms A signed on 16 April 2014), and the Programme Expectation Agreement (also signed on 16 April 2014). Ms A stated that she agreed to these restrictions because she was desperate to be well.

71. Ms A told HDC that all emails to residents were vetted by staff before being given to the intended recipient; however (as noted above), the facility said that emails were not read by staff except to identify the recipient. Ms A told HDC that residents were not allowed to call their family whenever they wanted to. As stated above, residents' cellphones were taken on arrival and kept in a safe. Ms A said that although there was a telephone available for use at weekends, it was in the staff office, and residents were supervised while using it. She said that residents could not call out on the phone, and only incoming calls were accepted, but the facility's telephone number was not provided to residents before they entered the house. In response, the facility stated that cordless phones were used to enable residents either to walk outside or to go to a different space in the home so that they could converse privately. The facility said that two landlines were available, and residents used their own calling cards for toll or mobile calls.

72. The facility stated that Ms I provided applicants with the facility's telephone number (to be used for their calls within the home) before they arrived at the home, and residents were given the after-hours extension number on arrival so that they could advise their friends and family of how to make incoming calls during a weekend.

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Journal

73. Ms A told HDC that she used to journal frequently, which helped her. She said that staff asked her to hand in her journal each week for her counsellor to read, but she refused to do so. Staff told her that they needed to see her journal in order to help her, and they asked what she was hiding from them. She said that she was required to have a meeting with Ms E because of this refusal, and Ms E told her that she was not committing to the programme. As a result, Ms A destroyed her journal and wrote a new journal including only things that she would not mind the staff reading. She said that she was too afraid to write anywhere else and felt that only her thoughts were private.

74. The facility agreed that Ms A was invited to share her journal with the counsellor, Ms J, and that Ms A was reluctant to do so. The facility said that when Ms A decided not to share the journal, the refusal did not affect the manner in which she was 'respected and honoured' in the home. The facility told HDC that the choice not to share the journal would have been respected fully and would not have resulted in a conversation relating to Ms A's commitment. The facility said that privacy is not a commitment issue.

75. In a counselling report dated 16 June 2014, Ms J noted that she invited Ms A to share her journal, but Ms A was reluctant to do so because she thought it would 'scare' Ms J. Ms J wrote that she assured Ms A that if she did become scared, she would 'address this in supervision and asked her to reconsider'. In a counselling report dated 28 July 2014, Ms J again referred to a journal entry.

76. Ms A was admitted to hospital several times during her programme for issues relating to her mental health (discussed below). HDC obtained patient notes from the then DHB1, which mention staff at the facility reading Ms A's journal. A note dated 2 September 2014 records a telephone conversation between a nurse and Ms E. The note records that Ms A had talked about wanting to end her life. The DHB1 note also records: 'Her counsellor has also read her journal (a counselling prerequisite) and the same theme is in the journal.'

77. In response to the provisional report, the facility said: 'It is not correct that it was a "counselling prerequisite" for personal journals to be read by their counsellor.'

Medical appointments

78. Ms A told HDC that she was required to change her GP to the medical practice recommended by the facility. She said that staff made appointments for residents and accompanied them to appointments. She told HDC that residents were not allowed to speak to the doctors alone and, as a result, she did not feel comfortable discussing some issues (such as purging) with the GP.

79. The facility has provided no record of Ms A having given consent to staff being present during her medical consultations. However, in response to the provisional opinion, the facility stated that it sought to support residents with their doctor's appointments, and the protocol was to check with the resident verbally at each appointment whether they would like staff to stay with them, and it was their personal choice.

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Scan

80. Ms A was admitted to hospital on 2 August 2014 with abdominal pain and had a transabdominal ultrasound scan (USS) that identified, as an incidental finding, a left ovarian cyst. The report mentioned that a follow-up USS in two weeks' time was required. However, the discharge summary states that she required a follow-up USS in 6–8 weeks' time if she still had symptoms.

81. On 13 August 2014 Dr K referred Ms A for a follow-up USS. On 22 September 2014 Ms A underwent a transabdominal USS and a transvaginal USS. The findings were of a 33ml simple cyst that did not require follow-up.

82. Ms A told HDC that Ms H stayed in the room while they conducted a vaginal USS and, when the radiologist asked Ms H to leave, Ms H said that she was a 'registered nurse' and that Ms A was unreliable, so she had to stay. Ms A said that eventually Ms H agreed to stand behind the curtain, but she remained within earshot. As stated above, Ms H did not hold an APC in 2014.[9]

83. The facility told HDC that its records show a calendar appointment on 22 September 2014 — '[Ms A] Ultrasound, 8am [DHB1] — but there is no reference to the staff member who took her to the appointment. Ms H does not recall the appointment. Similarly, the DHB1 records do not refer to the presence of staff at the USS procedure. The facility stated:

> 'Given the sensitive nature of this procedure, we are confident that a discussion with [Ms A] would have taken place regarding whether she needed support from our staff for this appointment. If [Ms A] had requested for staff to be in attendance and the radiologist had requested our staff to leave, we are also confident that this would have been totally respected, however there is no record of the details of this external appointment.'

84. Ms A said that she was told that she had a large cyst on her left ovary that required a repeat USS in two weeks' time. She said that after three weeks she asked Ms H if she had another appointment, and Ms H told her that they had decided that she did not need another USS and asked why she was not trusting the programme, which showed that she was not committed.

85. The facility stated that the ultrasound result indicates that no follow-up was required, and that the GP, Dr K, sent this to Ms A following the appointment. The email was sent to the facility 'admin', and there is no evidence that it was given to Ms A. However, the facility stated that although the report came into the admin account, it was addressed to Ms A, and it is confident that the report would have been given to her directly.

[9] Section 7 of the Health Practitioners Competence Assurance Act 2003 states that a person cannot claim to be a health practitioner unless they hold a current practising certificate.

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Counselling issues

86. Ms A's counsellor was Ms J. Ms J was registered with NZCCA (the New Zealand Christian Counsellors Association).[10]

87. Ms A raised concerns about some of the concepts Ms J used during the counselling sessions. Ms A said that Ms J discussed with her the concept of 'soul ties', in which God intends sex only for marriage, and that sex tears and binds two souls together, including non-consensual sexual contact. Ms A told HDC that Ms J asked her to write a list of all her sexual partners, including all sexual contact and not just intercourse, so that they could break the soul ties.

88. The facility said that co-dependency was explored in the counselling sessions, although never with the use of the term 'soul ties'. However, Ms A's Counselling Reports show that three months into her programme Ms A 'chose to pray some prayers of forgiveness, sexual soul ties and to break ties with the occult'.

89. Ms J said that nothing in her counselling reports points to her having instructed Ms A to write a list of sexual partners. Ms J told HDC that Ms A's sexual abuse and her abuser were discussed over two sessions, on 21 July 2014 and 28 July 2014. Ms J stated that she would not instigate this type of interaction unless it was therapeutically indicated and said that during the session on 21 July, she prayed 'to sever the ties to the man who raped [Ms A]'. Ms J said that this would have been a result of what was discussed in the session, given that trauma impacts the whole person, ie, the body, soul (which is the mind and emotions), and spirit.

90. Ms J told HDC that it is a commonly held Christian belief that the act of sex involves a spiritual component. However, she said that she did not infer or say explicitly that 'all sexual contact breaks your soul and ties them to you, including non-consensual assault' or that 'God would bind [Ms A's] soul to that of [her] abuser'. Ms J stated that she prayed with the intention of negating any fear that Ms A may have had that the abuser still had a controlling influence on her life. She stated:

> 'The use of the phrase "soul ties" is not a terminology that I currently use in my practice nor has been for several years, owing to regular development and evaluation of my professional practice and taking into account Christian societal shifts.'

91. The facility told HDC that counselling was client led, that applying such a concept as 'soul ties' as part of counselling practice would be unethical, and that the facility has never supported or facilitated the concept of soul ties in the way described by Ms A. The facility suggested that the words may have been used as a synonym for co-dependency, where a person becomes so dependent on someone else that their thoughts are consumed with that person, but typically the term 'co-dependency' would be used instead. The facility

[10] Counsellors in New Zealand are not regulated under the Health Practitioners Competence Assurance Act 2003 and so membership is voluntary.

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said that if the therapeutic relationship was as Ms A described, it would have been oppressive and discriminatory. The facility also told HDC:

> '[We] respect all participants' right to freely express their sexuality without fear of discrimination or judgement; this has always been our intention and is consistent with our values.'

92. Ms J told HDC:

> 'The process of forgiveness acknowledged the offence committed, and recognised the importance of working through anger and grief. It was a choice and initial decision to release those feelings of resentment and wanting revenge towards the person who had harmed [Ms A] so that he no longer had power over her. Forgiveness was discussed as a process over time not a one-off event.
>
> Prayer for healing was used as [Ms A] professed a Christian faith. Prayer included asking God to free her from negative attachment from the person who abused her.'

Consent to medication and seclusion

Ms A's complaint

93. Ms A told HDC that on one day while she was in the programme, she was feeling particularly down. This was noticed by staff, and she was pulled aside and asked how she was feeling. She admitted that she was feeling low and was taken into the room usually used for counselling. When asked by the staff member, she admitted to feeling suicidal, but she told HDC that the feeling was usual for her.

94. Ms A said that she was given some medication to take, which she was told her doctor had provided. She refused to take the medication, but she was pressured repeatedly by staff to take it. She said that because she had refused to take the offered medication, she was kept in the counselling room and not allowed back into the rest of the house. She was told that the reason was because she would be 'triggering' to other residents. She said that when she wanted to leave the room, the staff would not let her and said that she needed to stay alone in the room for now.

95. Ms A said that there was a bed in the counselling room, and she was kept in the room for a long period of time, during which staff would visit her periodically to pressure her to take the medication, using threats of Police involvement and sectioning her under the Mental Health Act.

96. Ms A told HDC that eventually, Ms E came into the room with a telephone. Ms A's mother was on the phone. Ms A said that her mother was crying, and when her mother asked her to take the medication and to 'trust the professionals', this broke down her resistance and she took the offered medication.

97. Ms A's mother, Ms C, told HDC that she talked with her daughter only two or three times while she was at the facility. There was one call from the hospital and a couple of others from the facility. Ms C said that one of the staff from the facility had to be in the room with

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her daughter when she called, and she was told that her daughter was not allowed her phone.

98. Ms C said that she remembers getting a phone call from the counselling room at the facility. The person who rang described herself as a nurse. Ms C stated: 'The call didn't feel like an emergency. They made it sound like [Ms A] was the problem and she wasn't doing what she needed to get well.'

99. Ms C recalls that the person who telephoned wanted Ms A to take some medication, but Ms C does not remember being told what it was. She said: 'It wasn't a long call but it felt weird. The staff asked for my support. I told them it was up to [Ms A] but what they were saying didn't really add up.'

100. Ms A described a 'hazy' period following this during which she was constantly sleepy, was taken to hospital twice, and suffered frightening hallucinations.

Facility's response

101. The facility told HDC that the facts described happened during two discrete incidents on 25 and 31 August 2014.

25 August 2014

102. The facility told HDC that Ms A had a 90 Day Review on 25 August 2014, which she found distressing and, following the review, she discussed her suicidal ideation with staff. The facility said that Ms E called the DHB1 Crisis Team, and a DHB1 nurse told Ms A that if she appeared to be intent on following through with her plan, the facility would have to involve the Police to take her for an assessment. The facility said that its staff made no threats regarding compulsory treatment orders under the Mental Health Act.

103. The DHB1 notes from 25 August 2014 record four telephone calls between the facility and the DHB1 Crisis Team. A nurse recorded that she spoke to Ms A, who discussed how she was feeling and said that she was taking fluoxetine 40mg but did not have any PRN (as required) medication. She refused to see the GP for any short-term medication options to minimise her distress or decrease her anxiety. There is no record that the nurse discussed Police involvement with Ms A (although it is recorded that she did discuss it with Ms E).

104. At 4.47pm a nurse recorded that she had spoken to GP Dr K, who had reviewed Ms A when she attended the surgery accompanied by Ms E. Dr K told the nurse that Ms A was ambivalent regarding PRN use, and they discussed a small dose of quetiapine 12.5mg mane (in the morning) and 12.5–25mg nocte (at night). Dr K told the nurse that Ms A had not assured Dr K of her safety, but she had said that she was happy to stay at the facility and did not want to be in hospital or respite care. Dr K said that she did not believe Ms A was presenting with acute suicidality. Dr K's records note that she prescribed 10 x 25mg quetiapine tablets, with half a tablet to be taken as needed.

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105. The facility stated:

> 'Though there was no record that medication would have been part of the efforts to secure safety for [Ms A], it would not be unusual that medication was an option.'

106. As noted above, the facility has not retained any medication records. The facility told HDC that Ms E would not have acted in the way described by Ms A, and Ms E did not at any point try to compel Ms A to take medication. The facility identified several occasions during Ms A's stay when she had declined medication and her choice had been respected.

107. The facility also said that it was aware that Ms A's mother was opposed to medication, and therefore it was unlikely that the telephone conversation happened as described by Ms A.

108. Ms A told HDC that her mother and stepfather told her that Ms E spoke to her stepfather first, because they could not get hold of her mother, and Ms E told him that Ms A was refusing to take her regular medication and that they were concerned that she was going to do something to harm herself. Ms A said that her mother told her that she feels very guilty for trusting staff.

109. The daily report dated 25 August 2014 states:

> '[Ms A] took a call from the crisis centre at 7:40pm this evening and reported to staff ([first name]) afterwards that it was recommended by Crisis Team ([first name]) that she take some medication (which she did) and play games on her phone. Although feeling nauseous, [Ms A] appeared settled and comfortable after having a shower and being set up on the counselling room bed. [Ms A] had some dinner and then went to sleep.'

110. HDC was provided with a Resident Contact Form dated 25 August 2014, which records Ms A's suicidal ideation on that day, the subsequent call to the Crisis Team, her refusal to seek short-term medication or other help, that the Crisis Team had said that the facility would need to involve the Police to take her for an assessment if she remained intent on following through with her plan, and a telephone call between Ms A and her mother.

111. The record of the call between Ms A and her mother notes that Ms A's mother did not support medication and wanted to be notified if there was any discussion of medication. There is no record of staff having spoken to Ms A's stepfather. The resident contact form does not record Ms A being put in the counselling room.

112. The facility told HDC that Ms A spent the night of 25 August 2014 in the counselling room, but that it was used the next day for counselling sessions, so she could not have stayed there for a longer period, and the records show that Ms A had a walk off-site the next afternoon. The daily record for 26 August 2014 states that Ms A had a 'restful day' and reported being unhappy with other residents' questions regarding her wellness. The record notes that after a walk off-site with staff, Ms A's disposition had changed and she was more engaged with the programme, with staff support.

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113. The DHB1 records state that on 26 August 2014 at 2.46pm Ms E spoke to the nurse and told her that Ms A had remained in bed for most of the morning and appeared to have slept well.

114. The facility has provided no records of the length of time Ms A spent in the counselling room, the reason for that, or whether she was permitted to leave. The daily report suggests that Ms A went for a walk on 26 August 2014. No Resident Contact Forms have been provided to HDC for the dates 26 to 30 August 2014. In response to the provisional opinion, the facility stated that if Ms A had remained in the counselling room between these dates, a Resident Contact Form would have been completed. The daily record for 28 August 2014 states that Ms A had reported feeling tired and said that she had not slept during the night, and the staff 'discussed options such as coming for support for prayer at night and utilising quetiapine'. The daily record for 29 August 2014 states that Ms A was 'visibly very low' during the morning but did not want to talk with staff.

115. In response to the provisional report, the facility stated that Ms A slept for one night in the room usually used as a counselling/meeting room. The facility said:

> 'This room was used on occasion when a resident was unwell or highly distressed to provide privacy for the resident and minimal disruption for the other residents who shared their bedroom and bathroom space. Seclusion or punitive actions are not a part of our kaupapa.'

116. The facility told HDC that there was no suggestion that Ms A was not permitted to leave this room and there was no lock on the outside of the door.

31 August 2014

117. The facility told HDC that on 31 August, Ms A again expressed suicidal ideation and refused the offer of a call to the Crisis Team or any other treatment options suggested by the facility.

118. A DHB1 note from 31 August 2014 records a telephone call between the DHB1 Crisis Team and the facility regarding Ms A's suicidal ideation that day and her unwillingness to engage in any treatment. The note states: '[the facility] are concerned that they cannot manage [Ms A's] current risk and so want her assessed and medicated this evening.' The Crisis Team registered nurse repeated the advice to call the Police if Ms A left the house.

119. The DHB1 notes then record Ms A's arrival at the ED late in the evening of 31 August 2014. She was admitted and kept overnight for her safety and administered zopiclone.[11] The notes record that following her night in the ED, she felt better and denied any further thoughts of self-harm. A telephone call is recorded between the DHB1 Clinical Coordinator and Ms E, in which they discussed Ms A's expressed wish to return to the programme and a plan to visit her GP to discuss her medication. Ms A was then discharged around midday on 1 September 2014.

[11] A drug used to treat difficulty sleeping.

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120. Following her discharge from hospital, Ms A began to experience hallucinations. The DHB1 patient notes record a call from the facility to the Crisis Team in which they discussed Ms A's hallucinations. She was admitted to the ED again in the evening of 1 September 2014 and administered lorazepam.[12] This appeared to calm her and reduce her symptoms, and she was discharged again late that evening.

121. Ms A stated that when she was taken back to the house, again she was put in the counselling room, where she remained alone for two more days. She said that she asked to leave a few times and, eventually, they asked her if she would pray for forgiveness and then she could re-join the rest of the girls. She said that she did so because she was 'sick of being in the little room' and wanted other people to talk to.

122. In response to the provisional opinion, the facility told HDC that following Ms A's discharge from hospital on the morning of 1 September she re-engaged with the programme, but around 4pm she told staff that she was having hallucinations. At that point she was taken to the counselling room, where she responded well to staff assurances of her safety and engaged in grounding exercises. On the advice of the Crisis Team, she was taken to the ED, where she was treated with medication to reduce anxiety. She then returned to the home so that she could sleep in her own bed. The facility stated: 'There is no rationale for, or evidence of, … her being asked to pray for forgiveness.'

123. The facility said that Ms A's mother, Ms C, was notified of the hospital admissions by telephone, in accordance with the facility policy and the Release of Information form signed by Ms A before her entry to the programme.

124. Ms C told HDC that around the time of Ms A's hospital admission, she was phoned by Ms A. Ms C said that there were staff in the room, and her daughter was not talking freely. Ms C said that her daughter said things like, 'I'm not allowed to talk about that, I can't talk about that,' which made her feel uneasy, and she became very hesitant dealing with staff. Ms C stated: 'I didn't feel like I had any control. [Ms A] was an adult who had chosen to go there but I definitely got a sense that she did not want to be there any more.'

125. In response to the provisional opinion, the facility stated that the resident contact form notes that while in hospital, staff suggested that Ms A text her mother to let her know what was happening. The facility said that the staff member left Ms A at hospital under the observation of the triage nurse. The facility noted that it is not congruent with Ms C's assertion that staff were present when Ms A called her, but it is possible that hospital staff were present at the time of her making the call.

Exit from the house

126. The facility told HDC that residents were not allowed to walk around freely outside the property due to conditions imposed in the facility's Council Consent. The Handbook tells residents to avoid being on gravel areas down the side of the house or on the driveway.

[12] Lorazepam is a benzodiazepine medication used to treat anxiety, trouble sleeping, severe agitation, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy-induced nausea and vomiting.

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Car parks and bush areas surrounding the property were out of bounds, and residents were not allowed to come on or go off the property without staff supervision.

127. The Handbook contains provisions relating to exit from the programme. The Handbook states:

> 'It is our hope that every resident will complete the full [facility] programme. However if you choose to leave without having finished the programme, you will still need to have your belongings checked out by a staff member.'

128. The facility's New Resident Orientation document also gives residents information about leaving the programme. The document states:

> 'If for any reason you do not want to stay at [the facility] and are adamant about that decision, we will see to it that you are able to leave. We do not force people to stay here, although you have signed a 6 month agreement that you would. A choice to leave is not instantly acted up (for e.g. if you decide in the weekend), you will be expected to meet with your counsellor and the programme manager to discuss. You cannot change your mind and return a few days after you have left.'

129. The Staff Handbook contains instructions to staff about residents' voluntary exits. It reminded staff that the programme was voluntary, and residents could always request to leave permanently. The Handbook states that if a resident made a decision to leave, her exit was not to be processed immediately, and a discharge process was required. A risk assessment was required, and the resident's emergency contact person was always advised in order to arrange the resident's safe return home. This process was handled by day staff, so if the resident wished to leave when day staff had gone home for the day, the resident had to wait until the following day.

130. Ms A said that she was nervous when she arrived because the location of the house was a secret, and staff met her at another location and took her to the house. As she was not familiar with the region, she did not know where she was. However, three girls left the programme during the first couple of days she was there, so it seemed easy to leave, which put her at ease. In response to the provisional opinion, the facility said that Ms A was told the address of the house prior to her arrival and, as she arrived on a flight from another region, Ms I collected her from the airport bus depot.

131. On 20 October 2014 (a Monday) Ms A decided to leave the facility. She said she told the other residents that she would be leaving and asked the staff to give back her phone and money from the safe, so that she could leave. Ms A stated that staff member Ms L told her that she needed to talk to Ms E about it first.

132. Ms A said that the staff refused to give her belongings to her and told her to wait until the morning and speak to Ms E. Ms A told HDC that she repeatedly asked them to give her phone and wallet to her and said that she would come back the following day to get the rest of her possessions and talk to Ms E, as she wanted to leave then and did not want to stay for the night.

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133. Ms A stated that the staff asked her where she was going to go, and she explained that she was going to get a room in a hotel that night and fly home in the morning after she had seen Ms E. Ms A said that the staff continued to refuse to give her phone and wallet to her, and they said they did not think it was safe for her to leave the programme.

134. Ms A said that she 'felt upset and panicked' and tried to sneak out of one of the side doors, but staff blocked her way and asked her what she was doing. She said she told them that she was just going to go for a walk to cool down. She stated that Ms L followed her and, when they reached the end of the street, Ms L asked what she was doing and blocked her path. Ms A said that she repeated that she wanted to leave now and asked Ms L to get out of her way, and Ms L told her that if she tried to leave, she would have to call the Police.

135. However, the facility told HDC that there was a 'civil discussion' between Ms A and Ms L. The facility's record of the interaction between Ms A and Ms L from 20 October 2014 notes that Ms A told Ms L that she wanted to leave the house for the evening, come back later, and exit the programme in the morning. It then states:

> '[Ms A] was unwilling to work with Staff until [Ms L] verbally processed out loud how she could make something work so [Ms A] could have space but still in the context of [the] program.'

136. The record notes that Ms A asked if she could call her mother, and that Ms L and Ms A went for a walk together and then Ms L facilitated the call to Ms A's mother, after which Ms A's disposition changed because her mother told her that she would be attending her graduation from the programme. Ms L recorded that she asked Ms A to follow the exit procedure, which included waiting until the next morning. The facility said that Ms L did not physically prevent Ms A from leaving or make threats of Police involvement.

137. In response to the provisional opinion, the facility stated that there is no evidence of a consistent request to leave the home on the night of 20 October or of Ms A requesting her belongings or packing her bag.

138. Ms A told HDC that she returned to the house reluctantly and packed up her possessions ready to leave first thing in the morning. She said that the following morning, she was told that she would have to wait to see Ms E as she needed to talk to her and complete paperwork before she could go. After some time, she went into the office to see Ms E and found that Ms E was on the phone with Ms A's mother. Ms E handed Ms A the phone and listened while Ms A tried to explain to her mother that they had stopped her from leaving and that she wanted to get out now.

139. Ms A said that Ms E had told her mother that Ms A could leave if she wanted but that the staff did not think it was a good idea. Ms A told HDC that her mother said that she would be very disappointed if Ms A left before graduation and told Ms A that she would come to her graduation then take her home if that was what she wanted. Ms A said: 'I felt like I wasn't being listened to and I didn't have a choice so I agreed to stay until graduation.'

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140. In response to the provisional opinion, the facility stated that if there had been conversations between Ms E and Ms C on this day, this would have been a significant event that would have been recorded, but there is no record of it.

141. Ms A stated that the meeting with Ms E occurred on 21 October 2014. However, the facility provided no record for the meeting, and said that the only reference in the daily report for that day is Ms A's request for a room change and a discussion about her class module evaluation.

Effects of time at the facility

142. Ms A told HDC that the programme still affects her. She said that she has nightmares about being at the facility and not being able to leave. She stated that she tried to tell people what had happened there a few times, but they did not believe her, and she was afraid of going to any health professional such as her GP, and she refused to continue with counselling.

Complaint Ms B (22HDC03037)

Introduction

143. Ms B began abusing alcohol at the age of 16 years and had two admissions to hospital. On 24 December 2013 Ms B was treated at DHB2 Intensive Care Unit (ICU) for an alcoholic coma. She had been found on the side of the road and was taken to ED and intubated. She was extubated but had to be reintubated after she harmed herself.

144. Ms B was referred to the mental health unit and admitted under section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA) until 17 January 2014. It was noted that she had low levels of potassium in her blood.

145. Ms B told staff that she had been medicating her anxiety with alcohol, reaching an intake of about eight bottles of wine per week. She said that she had panic attacks and felt that alcohol helped to relieve her anxiety. She told staff that she had been drinking about 24 standard drinks (SDs) per week for eight months.

146. Ms B told HDC that she had an out-of-control eating disorder and started self-medicating with alcohol as a way to manage that and rapidly became an alcoholic. A psychiatrist saw Ms B in February 2014 and recorded that she had recommended the facility to Ms B.

Admission to the facility

147. Ms I sent Ms B the Handbook on 26 March 2014 and the new resident pack on 28 March 2014. Ms B received a New Resident Orientation document, a Standards Agreement, and a Programme Expectation Agreement. Ms B completed the preadmission processes and entered the facility on 7 April 2014, aged 18 years. She told HDC that this was shortly after she had left high school.

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148. Ms B told HDC that she was immediately struck by the isolation. The residents were not allowed outside media, music, or non-Christian literature. She said that the facility was 'very one size fits all' and did not utilise individual treatment plans. However, the facility did provide HDC with a care plan for Ms B dated 7 April 2014.

149. Ms B said that the residents were not permitted to speak to each other about their problems, which was very difficult for her because alcoholism and bulimia are very isolating illnesses.

150. Ms B told HDC:

> 'There were so many rules and restrictions. This, coupled with the intense surveillance, made it another level of controlling. Most of the restrictions had no relation to the problems I was there to recover from. I'm not sure if the facility displayed the HDC Code of Rights at the house. I don't think they did. This would be something I'd remember because knowing my rights were being breached would have stood out in my mind.'

151. Ms B said that there was no meaningful effort to make sure residents were aware of their rights and, as phone calls out were nearly impossible, she felt completely isolated.

Facility staff

152. Ms B said that the executive director Ms D[13] and Ms E managed the facility. Typically, Ms H, Ms E, or Ms L would run classes. Ms H and Ms E made any decisions regarding residents' treatment, and Ms L managed the support staff. The programme intake was decided by Ms I.

153. Ms B told HDC that there was a strong power dynamic at the facility. Ms E and Ms H 'ruled'. The facility staff attained power by being 'experts' and by the residents being 'patients'. The staff had information and access to information. Ms B said that during her time at the facility, Ms H and Ms I both claimed to be registered nurses. However, after leaving the facility she realised that neither were on the New Zealand register of registered nurses.

154. As stated above, the facility told HDC that Ms H and Ms I were trained and qualified as registered nurses but were not employed in that capacity. The facility told HDC that Ms H was registered with the Nursing Council from 2003 and held an APC until 2011. The Nursing Council told HDC that in 2014 Ms I was registered with the Nursing Council but did not hold an APC.

155. The facility said that Ms H interacted with Ms B on most weekdays supporting her in the programme. Ms H's role was to be available for individual support and to respond to any medical concerns, ensuring that medical appointments were organised. Ms H oversaw the

[13] Ms D has oversight of the facility. She is responsible for the financial, HR, administration, and fundraising aspects of the organisation. She is a part of the Intake Committee. She liaises with the Programme Manager to discuss programme matters, offering support as required.

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recording of the residents' medication, facilitated classes, and supervised fitness and recreational activities.

156. Ms B said that the staff would imply or threaten punishments. Sometimes these were very direct, such as increasing Ms B's 'sit time' (after having eaten) or not allowing her to wander off on outings. At other times, these were less direct. For example, Ms B would say something, and staff would look displeased, then she would find out that a request form had been denied with no adequate explanation. She said that disagreeing with staff decisions was against the facility's rules.

157. In response to the provisional opinion, the facility stated that 'sit time' is a therapeutic tool to help residents who struggle with purging following meals. The facility said that it did not use 'sit time' after meals as a punishment. It said that Ms B's 'sit time' was reduced gradually then ceased, and it was never increased.

158. Ms B said that the residents could submit request forms for things outside the norm, such as access to their phone, or access to extra money, media, and the like. She said that she submitted many request forms because she wanted her music so badly, and to be able to call her family when she was sad. She stated that the only request the facility ever allowed was for her to have a couple of books. Usually they did not give explanations, and she would just submit the requests then hear nothing, or the request would be denied because it was said to be not appropriate for her treatment.

159. The facility stated: 'We respect and understand that her recollection and feelings around this significant period of her life may differ from what is reflected in our records and kaupapa.'

Counselling

160. The facility told HDC that Ms B's counsellor was Ms G, who has a Diploma in Counselling and a postgraduate Diploma in CBT and was registered with NZAC. The facility said that Ms B and Ms G met for counselling on a weekly basis for approximately one hour. Ms B and Ms G had 10 sessions together until Ms G finished at the facility. The facility said that Ms J met with Ms B on one occasion when Ms G was on leave. After Ms G left, Ms F then took over the counselling role for Ms B and they completed a further two sessions. The facility told HDC that Ms F was a provisional member of NZCCA from August 2012, and her membership was put on hold in November 2014. Her membership was cancelled in April 2018 as she no longer works as a counsellor.

161. The records of the counselling sessions are largely positive and, apart from 1 July 2014 (discussed below), generally they do not refer to Ms B having had struggles or having purged while at the facility.

Medication and medical appointments

162. Before entering the facility on 25 March 2014, Ms B signed a Medical and Property Release Agreement that stated, among other things, that she gave 'authorization and consent for the facility to both release information and obtain appropriate medical, social,

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educational, psychological, dental and/or other services as they deem appropriate' (emphasis in original). There is no record of this form having been provided to Dr K.

Diazepam

163. Ms B said that the staff operating the facility knew very little about medication, including what the medications had been prescribed for or when they should be administered. She stated that she was prescribed diazepam[14] for alcohol withdrawals, but rather than assessing her for withdrawal symptoms, the staff would simply ask if she wanted diazepam. However, Ms B stated that she now knows that medication should not be administered without a genuine reason.

164. It appears that Ms B took the diazepam to the facility when she was admitted, and it was held by the facility and administered by the staff. The Medicine Overview Chart dated 9 April 2014 lists diazepam as one of Ms B's medications and states: 'Take l x 2mg tablet as required for alcohol withdrawal.' However, given the failure by the facility to retain medication records, it is not possible to verify how frequently the medication was administered or the reasons for the administration, while she was there.

165. The medical centre told HDC that Ms B was not prescribed diazepam while a patient there. The medical centre record on 23 April 2014 states that Ms B had 'earlier had diaz[15]', and on 4 July 2014 it records that she had had Valium in the past.

Blood test results

166. On Friday 25 April 2014 Ms B's routine blood test showed that her bicarbonate level was high at 34 (normal 22–31), and her phosphate level was also high at 1.9 (normal 0.7–1.5). Dr K recorded that she talked to Ms D, who said that Ms B was 'OK'. Dr K recorded: 'I am unsure about the [significance] of these abnormalities.' She noted that as Ms B was well, and as the facility did not have full staff on weekends, she and Ms D had elected not to 'confront' Ms B that day, and Ms D would talk to her on the following Monday.

167. In response to the provisional opinion, Dr K said that her first priority after receiving the reports was to ascertain the potential significance of these results and dangers to Ms B's safety. Dr K stated that she cannot remember the exact situation at the time, but from her notes, it appears that she doubted the wisdom of confronting Ms B with the results at the start of a weekend, when further support would be more difficult to obtain. Dr K stated: 'In hindsight, I acknowledge that I could have made a bigger effort to contact [Ms B] personally and I apologise to her for this omission.'

168. On 30 April 2014 Ms B's blood test results showed low sodium at 130mmol/L (normal 135–145), very low potassium at 2.5mmol/L (normal 3.5–5.2mmol/L), and high bicarbonate at 38mmol/L (normal is 22–32mmol/L in adults).

[14] Diazepam (brand name Valium) is a highly addictive benzodiazepine, and withdrawal symptoms can be severe.
[15] Diazepam.

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169. The resident contact form for 30 April 2014 states that the staff had received a call from Dr K regarding the results of Ms B's blood test (which had yet to be reported formally) and that Dr K was concerned about the low potassium level (the level is not recorded in the resident contact form). Dr K told staff that she would talk to a 'specialist' about whether Ms B needed to be in hospital that night because of the low potassium and then she would contact the staff again. In response to the provisional opinion, Dr K said she could not remember the conversation with the hospital in detail, but she left it up to the registrar to decide whether Ms B's condition warranted admission.

170. The resident contact form states that Dr K contacted the staff again to check Ms B's current potassium medication and said that there was another medication that would be absorbed faster, which Ms B needed to take that night. The form records that Dr K said that she was 'ok' with Ms B staying in the home that night provided she took this (unnamed) medication. Dr K faxed a script through to an open pharmacy for the staff to pick up. The form noted that Dr K said that Ms B must be purging for her potassium to be so low, and the doctor was concerned about how they could prevent Ms B from purging that night.

171. In response to the provisional opinion, Dr K stated that she cannot remember whether she ever saw the Medical and Property Release agreement that Ms B had signed, but she acknowledged that she should have taken steps to ensure that she had Ms B's consent to discuss her results with the staff, before doing so. Dr K said that her main motivation for talking to the staff was to ensure that Ms B was not experiencing any symptoms, and, when she was reassured that Ms B was 'well', she felt it was appropriate to arrange a repeat test and to talk to Ms B about the results in an appointment the following week.

172. Dr K noted that after Ms B's initial abnormal test on 25 April 2014, she arranged for a repeat sample, which was taken on 30 April 2014, and she then saw Ms B in person on 2 May 2014, at which time she examined her, discussed the results, and arranged on-going monitoring.

173. Ms B told HDC that she was aware that she had had low potassium levels previously, for which she had been hospitalised. She was also aware that low levels can cause adverse effects such as heart arrhythmia. She told HDC that she believes she should have gone to hospital, but after the caller had spoken with the on-call staff member, it was decided that Ms B would stay at the facility.

174. In response to the provisional opinion, the facility said that the decision for Ms B not to go to hospital was the result of a discussion between the hospital specialist and her GP.

175. Ms B told HDC that she had no say about whether she would go to hospital, as staff took the call, then the staff member called her into the office. She said that she would have been pleased to go to hospital because as well as keeping her safe, it would have taken her out of the house. She stated: 'Then they made more calls and I wasn't going. I didn't hear them assert that I wanted to go. I don't think they even asked me.'

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176. The resident contact form for 30 April 2014 states that the staff informed Ms B of her low potassium level, and she appeared quite shocked and could not understand why her potassium was low. The form records that Ms B told staff that she had not purged for the previous two days but had done so before that. The form states that Ms B 'continued to be particularly fixated on her low potassium and the new meds she was going on and what dose they were'. Ms B told the staff that she was very against taking Span-K (potassium tablets) and said that when she had been on this previously her potassium had been low at times, even when she was not purging.

177. On 1 May 2014 Dr K emailed the facility 'admin' that Ms B's blood test results the previous day had shown a very low potassium level of 2.5mmol/L. There is no indication that this email was copied to, or provided to, Ms B. However, the facility told HDC that it is confident that anything addressed to Ms B would have been given to her. The facility said that there is evidence of discussion with Ms B regarding her taking the prescribed medication and her follow-up care.

178. Dr K suggested in the email that the potassium level could be related to purging. She stated that the potassium level was of concern and that she had talked to a medical registrar, who suggested '3 Chlorvescent[16] last night (keep the rest), then 3 days of three times three Span-K (9 daily)'. Dr K recorded that she had been contacted by the laboratory about the low potassium level and she had talked to 'Ms M'[17] at the facility, who said that Ms B seemed 'ok'. The facility said that Dr K asked the staff whether Ms B was acting unusually during the evening and whether she had eaten dinner. In response to the provisional opinion, Dr K acknowledged that it would have been best practice for her to examine Ms B in person rather than to rely on staff observations.

179. Dr K ordered blood tests twice weekly for three weeks. By 18 May 2014 the test results were normal, although Ms B's bicarbonate result remained at the upper limit of normal.

Staff at medical appointments

180. Ms B told HDC that during medical appointments she could not speak honestly about how she was struggling at the facility because the staff insisted on attending the appointments with her. She stated:

> 'During one GP consultation, I wanted so badly to speak with her honestly. I knew I was struggling, I wanted to tell her about my history of low potassium and see if there was any way I could get medication and prevent staff from knowing to avoid the inevitable punishment. I wanted to tell her how I felt the staff were not helpful. I wanted her to understand, perhaps advocate for other treatment options. Maybe if she could tell my parents the truth about the facility they would understand if I left. All this was impossible because the facility insisted on having staff present.'

[16] Chlorvescent tablets are used to provide extra potassium for people who have low levels of potassium.

[17] Staff member. The facility said that Ms M has a Bachelor of Arts majoring in Psychology and was completing postgraduate studies in Psychology. The facility did not indicate that Ms M had nursing or other clinical qualifications.

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181. The medical centre told HDC that it is not noted in the Daily Record whether staff were present during Ms B's consultations.

Exit from the programme

182. On 1 July 2014 Ms B had her final counselling session. Ms F recorded that they discussed Ms B's fear that she would be denied weekend leave or other activities if she admitted that she was struggling. Ms F noted that she had reiterated that they were not going to punish her for struggling and that their role was to support her in this. Ms F agreed that Ms B was ready to practise being unsupervised at the mall and noted that Ms B's main trigger was during the mealtime, when she was tempted to buy Coke Zero. They agreed that Ms B would decide what she was going to buy for lunch and tell the volunteer before she went, to help with this.

183. On 4 July 2014 Ms B went on an outing to the mall, during which she drank a bottle of cooking wine and took eight paracetamol tablets. When she returned to the facility she appeared intoxicated and was taken to the GP practice, where she became unresponsive, and an ambulance was called. She was transported to the ED.

184. In response to the provisional opinion, the facility stated that it notified Ms B's parents of the ED admission. Its Resident Contact form of 4 July records:

> 'A discussion was held with [Ms B's] parents who have also contacted the hospital and [Ms B's] alcohol blood level is 78 which her mother reports to be a very good level in comparison to her past alcohol abuse.'

185. On 5 July 2014 Ms B had a mental health assessment at DHB2. She denied an intent to kill herself the previous day and acknowledged that she had self- harmed as a way to go home for the weekend. She said that she would be safe if she could go home to her parents, but she was unable to give any safety assurances if she returned to the facility over the weekend.

186. A psychiatrist contacted Ms B's parents, but the hospital staff were unable to get hold of any staff at the facility, and the answerphone had a message stating that the facility was closed for the Christmas holidays (despite it being July at the time). DHB2 staff recorded that the facility had not notified Ms B's parents of her ED admission, but once her parents were informed, they told the psychiatrist that they were willing to come to the ED and take her home. Ms B did not return to the facility.

Request for donations

187. On 18 July 2014, after Ms B had left the facility, Ms E emailed to her:

> 'Although you didn't have time to organise your financial partnering with us, as an investment in to your journey here, we hope that you and your parents will have some time to reflect and consider partnering with us as so that others may benefit from our service.'

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188. Ms B told HDC that staff raised the topic of donations early in her treatment and encouraged the residents to sign up for regular weekly transfers as the 'treatment' was a gift, so they should give back. Ms B said:

> 'Many patients did do this, but I did not. It didn't feel right, it made me uneasy. I knew I wasn't getting better. I felt like they wanted an answer from me, so I said I will after I leave and am working. I have not [done so].'

Effect of the facility

189. Ms B said that she did not get better at the facility, and she felt worse in herself afterwards and became fearful of treatment, avoiding it for as long as she could. She stated: 'This mindset, I developed as a direct result of the "treatment" at the facility, meant I wasted a lot of time and risked dying from my illnesses.'

Reason for complaint

190. Ms B told HDC that initially she complained to HDC to support Ms A's[18] complaint because she knew that the facility would deny the complaint or fabricate how they operated. However, revisiting her experiences and remembering the facility and the impact it has had on her has made her want to complain for herself too.

Responses to provisional opinion

Ms A and Ms B

191. Ms A and Ms B were provided with the 'information gathered' section of the provisional opinion. Through their legal counsel they stated that they were both subject to a 'no talking' rule imposed by the staff after Ms A and Ms B became friends. Both Ms A and Ms B said that this rule affected their time in the facility.

192. Ms B stated that she was particularly affected by the 'no talking' rule, and it was a part of why ultimately, she drank cooking wine and took eight paracetamol tablets (as outlined in paragraph 183 above).

Dr K

193. Dr K's responses to the provisional opinion have been incorporated into the 'information gathered' section where appropriate. In addition, she stated that because of the length of time since these events occurred, she does not have a good memory of the specifics that may have affected her decision-making.

194. Dr K said that she accepts the adverse comment made in the provisional opinion and stated: 'I am happy to apologise to [Ms B] for any distress that my involvement in her care has caused her.'

Ms J

195. Ms J stated:

[18] Ms B and Ms A were residents at the facility at roughly the same time.

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> 'I believed the therapeutic relationship with [Ms A] was one of empathy and trust, where I showed respect, positive regard, care and compassion. I believed that counselling was a safe space for [Ms A] to express herself without being judged. I am deeply concerned that [Ms A] feels she was negatively impacted from my counselling sessions. I am happy to follow your recommendations and provide an apology to her.'

Facility

196. The facility's responses have been incorporated into the 'information gathered' section as appropriate.

197. The facility agreed that it was a healthcare provider and that its services should have been provided in accordance with the Code.

198. Regarding it not being certified under the Health and Disability Services (Safety) Act 2001, the facility asserted that this was not a deliberate omission but a misinterpretation of the requirements, and its understanding of its role in this sector.

199. The facility stated that it sought advice around the certification of its services and made several enquiries to various organisations, including the Ministry of Health. The facility stated:

> 'Our enquiries concluded that due to the bespoke nature of our services there was no appropriate audit service available. This was again readdressed several years later with the same conclusion.'

200. The facility accepted that its Long-Term Filing Guide document was incorrect in that the dispensing medication charts were kept for only 12 months. It said that the rationale for this was that the facility held a resident's medication on their behalf, and it was administered at the request of the resident and on the instructions of a medical professional such as a GP.

201. Regarding its staff attending medical appointments with residents, the facility said that its practice was to work with the residents and consult with them as to the level of support they wanted. It agreed that it would have been better to require residents to specifically request staff support if required, and for this to have been recorded. However, it disagreed that there was any coercion or insistence for a staff member to be present in any procedure or consultation.

Opinion: Introduction

202. In its initial response to HDC, the facility asserted that it was not a medical treatment centre or facility. It later accepted that it was a healthcare provider. For clarity about what constitutes a healthcare provider (see paragraphs 202 & 203), in this report I have retained my findings of the facility as a healthcare provider.

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203. Pursuant to the Health and Disability Commissioner Act 1994 (the HDC Act), a healthcare provider means any person who provides health services to the public, whether or not any charge is made for those services.[19] Health services include counselling services and any service offered to promote or protect health.[20] Healthcare providers are required to provide health services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code).

204. The stated aims of the facility include 'providing a place to heal and strengthen based on the Te Whare Tapa Wha model of health', and the organisation exists for the benefit of young women 'facing mental health challenges including anxiety, depression, disordered eating, self-harm and suicidal thinking'. The facility also employed counsellors who provided counselling services to residents. I consider that the facility was a healthcare provider subject to the HDC Act and was required to provide services to residents in accordance with the Code, even if the treatment was largely or entirely faith based. In particular, Right 4(2) of the Code[21] requires that services comply with legal, professional, ethical, and other relevant standards.

205. For completeness, I note that I have obtained independent advice from Mr Hanton with respect to Ms A's complaint only. I did not ask Mr Hanton to provide advice on Ms B's complaint. The reason for this is because the key issues raised by both complaints are materially similar, and the relevant events occurred at approximately the same time, and therefore the standards and legal requirements to which the facility was subject remained the same for both complaints. Accordingly, in my opinion, I can rely on Mr Hanton's advice to determine the appropriate standard of care in both cases.

206. First, I will consider the aspects that applied similarly to both complainants. I will then cover the aspects that apply to each complainant individually.

Opinion: Care of Ms A and Ms B

Legal requirements — breach

207. The facility was not certified under the Health and Disability Services (Safety) Act 2001. Section 9 of the Health and Disability Services (Safety) Act 2001 states that providers of healthcare services (which may include residential mental health services of the kind provided by the facility) must be certified. It is an offence to fail to comply. As noted above, HDC liaised with the Ministry of Health (HealthCERT) about the facility, and the information HDC received indicated that the facility was legally required to be certified. As such, my opinion will proceed on this basis.

208. Section 27 of the Health and Disability Services (Safety) Act 2001 states that, inter alia, in order to be certified, an auditing agency must have given the Director-General of Health a copy of a recent audit report. The facility had not been audited and had not arranged for

[19] Section 3(k) of the Health and Disability Commissioner Act 1994.
[20] Section 2(1) of the Health and Disability Commissioner Act 1994.
[21] Right 4(2) states: '2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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any independent review of its services. My independent advisor, Mr Paul Hanton, an expert in the management of therapeutic communities, identified that as a residential centre, the facility should have been registered and should have been audited every three years.[22]

209. Ms A and Ms B were administered regular and/or PRN medication while they were residing at the facility. However, the facility did not retain its medication records. The facility said that this was because its policy titled 'Long-term Filing Guide' instructed staff to keep medication charts and medical receipts for only one year from a resident's exit from the transition phase of the programme, or their exit from the home if there was no transition phase. The Health (Retention of Health Information) Regulations 1996 requires providers (as defined in regulation 4) to retain health information for a period of 10 years, beginning on the day after the date shown in the health information as the most recent date on which a provider provided services to that individual. It is an offence to fail to comply with the regulations. In addition, I note that Standard 2.9 of the NZHDSS requires services to ensure that '[c]onsumer information is … accurately recorded'. In my view, the facility was legally required to retain the residents' health records for 10 years, and it failed to do so. I note that Mr Hanton was also critical of this failure.

Conclusion

210. The facility failed to comply with legal standards in that it was not certified or audited and failed to retain health records. I acknowledge the facility's submission that it did not deliberately omit to be certified but rather it misinterpreted the requirements and misunderstood its role in the sector. I also acknowledge that it did take some steps to clarify its certification requirements. However, despite these attempts and irrespective of the reason for the failure, the facility did not comply with the legal requirements. Consequently, the facility failed to provide services to Ms A and Ms B that complied with legal standards, and therefore I find that the facility breached Right 4(2) of the Code with regard to each complainant.

Staff qualifications — adverse comment

211. I also note Ms A's and Ms B's concerns that the facility led them to believe that Ms H and Ms I were registered nurses. Ms H was not registered with the Nursing Council at the relevant time and neither Ms H nor Ms I had an APC. I note that section 7 of the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) makes it an offence for a person to imply that they are a registered health practitioner if they do not hold a current practising certificate, or for another person to make such a statement. Although this provision is directed at individuals, rather than organisations such as the facility, in my view the facility had an analogous responsibility not to imply to residents that its staff were registered health professionals if that were not the case.

[22] At the time of these events, the relevant standard was the Health and Disability Services Standard NZS 8134:2008 (now replaced by the Ngā Paerewa Health and Disability Services Standard, which came into effect on 28 February 2022).

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212. Both Ms A and Ms B told HDC that they believed Ms H and Ms I were registered nurses when they were not, and I have not seen any evidence to show that the facility explained their roles clearly to the residents. The facility denies that it implied that Ms H and Ms I were registered nurses by alluding to their training. Based on the evidence before me, I am unable to determine whether the facility implied that Ms H and Ms I were registered nurses; however, I would be very concerned if it did.

House restrictions and privacy — adverse comment

213. Ms A's and Ms B's descriptions of the programme include several restrictions on, and requirements for, Ms A, Ms B, and the other residents. Ms A and Ms B also described procedures that affected their privacy, such as mail being opened, and emails being read by staff.

214. For brevity, I have not dealt individually with every point raised by Ms A and Ms B. However, I have read their complaints carefully and have considered all the issues raised. I note that before they commenced the residential programme, they were each provided with a comprehensive Handbook, a New Resident Orientation document, a Standards Agreement, and a Programme Expectation Agreement. These documents detailed most of the restrictions on, and requirements for, residents who entered the programme.

215. I acknowledge that neither Ms A nor Ms B read these documents in detail and so did not realise the extent of the restrictions in advance, and that once they were aware of the restrictions, they remained because they were desperate for help.

216. The procedures, restrictions, and requirements contained in the Handbook and other documents may appear harsh in a non-therapeutic context. However, they were provided to Ms A and Ms B before they entered the house, and they had time to review them and decide whether they consented to entering the programme subject to the restrictions.

217. A consumer may choose any form of treatment available to them, including those representing a particular world view and/or involving compliance with certain restrictions. Ms A and Ms B agreed to the restrictions, and consequently I find that the facility provided sufficient information and time for Ms A and Ms B to consider that information before they were admitted to the facility.

218. I have also considered whether those restrictions and requirements were reasonable. Mr Hanton advised me that the restrictions detailed by Ms A, for example the absence of television, and ensuring that residents did not become too close to one another, highlight accepted practice in therapeutic communities. He also advised that the privacy restrictions, for example opening letters in front of staff, were also accepted practice in therapeutic communities. Although Mr Hanton considered the alleged redacting of newspaper articles to be odd, he identified no departures from the standard of care in respect of restrictions in the house or privacy intrusions. I accept that advice, although it is clear to me that the complainants did not understand the rationale for these restrictions, and I would expect this to be outlined clearly as a key part of people understanding what they are consenting to.

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219. I also take this opportunity to remind the facility that it works with traumatised people and must therefore be cognisant of how potent therapies can be in eliciting positive and negative outcomes. The facility should ensure that it operates from a least restrictive approach, as per the Health and Disability Services standards.

Staff in consultations — adverse comment

220. I am concerned that the expectation of the facility was that its staff members would accompany residents to medical appointments. Both Ms A and Ms B raised similar concerns that they were coerced into allowing staff to be present at medical consultations and that they believed that a refusal would have resulted in adverse consequences. Both said they felt that the presence of staff at consultations impaired their ability to speak freely and ask for help.

221. Ms A was concerned that Ms H insisted on being present while she was having a vaginal USS. Ms B raised a similar concern in relation to visits to the GP. The facility told HDC that its staff transported residents and supported them in consultations depending on the resident's consent. The medical centre has no records of when staff were present or of Ms A or Ms B having given consent to this.

222. While I acknowledge the facility's submission that there was no coercion or insistence for a staff member to be present in any procedure or consultation, given that both Ms A and Ms B complained about this issue, and the similarity of their experience, I accept that both complainants felt coerced into allowing staff to be present at medical consultations. In light of the extent to which the residents were isolated from the outside world, I am very critical of this practice.

Opinion: Care of Ms A

Withdrawal of consent — breach

223. Ms A was not permitted to leave the facility when she informed staff that she wanted to go. Ms A alleged that she was refused her belongings, physically blocked from leaving the premises for a time by a staff member, prevented from continuing when walking down the street, and threatened with Police involvement. However, the facility told HDC that there was a civil discussion between Ms A and Ms L, and they then took a walk outside the house together. The facility said that Ms L asked Ms A to follow the exit procedure, which included waiting until the next morning, but she did not physically prevent Ms A from leaving or make threats of Police involvement.

224. Ms A needed, at a minimum, her money and cellphone to be able to leave, but Ms L refused to give her these. Ms A agreed to return the following day to complete the exit formalities if she was permitted to leave immediately.

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225. The record of the interaction between Ms A and Ms L from 20 October 2014 notes that Ms A told Ms L that she wanted to leave the house for the evening, come back later, and exit the programme in the morning. The record also shows that Ms A was not told that she could leave, but instead Ms L discussed how Ms A 'could have space but still in the context of [the] program'. The record notes that Ms L later facilitated a call to Ms A's mother, on Ms A's request, after which Ms A's disposition changed because her mother told her that she would be attending her graduation from the programme.

226. The facility provided no record for 21 October 2014, which is when Ms A said the meeting with Ms E occurred.

227. It is common ground that Ms A sought to leave the house immediately on the evening of 20 October 2014, and that she was told that it would not be possible to process that request until sometime the following day. 'Process' in this context appears to refer to (at a minimum) discussion about the exit with day staff, completion of exit documentation, a risk assessment involving the resident's whānau and support people, and retrieval of Ms A's personal items, including her phone and purse, from a safe. The facility's procedures envisage a 24-hour timeframe to process a resident's exit. The facility stated in response to the provisional opinion that Ms A subsequently changed her mind about leaving. In my view, that is not the point. I remain of the view that at the time Ms A expressed a wish to leave, her departure should have been facilitated.

228. Mr Hanton advised:

> 'There may have been coercion in terms of keeping [Ms A] in the premises when she expressed a desire to leave. If this is proven it is a serious departure from standards.'

229. I accept Mr Hanton's advice.

230. Right 7(7) of the Code states that '[e]very consumer has the right to refuse services and to withdraw consent to services'. I consider that Ms A withdrew her consent on 20 October 2014 and so the facility should not have prevented her from leaving by withholding her cellphone and money. The facility should have facilitated her departure, for example by ensuring that she had means of payment available (by returning her wallet), and means of contacting support people (by returning her phone), and that she was able to arrange safe transportation and accommodation for the night.

231. There is no evidence that Ms A was suffering a mental health crisis on 20 October 2014 and, in any event, had there been concerns about her safety, the facility should have contacted the DHB1 Crisis Team or the Police.

232. I find that the facility breached Right 7(7) of the Code in that it had a procedure that did not support withdrawal of consent to treatment consistent with the Code of Rights and did not return Ms A's possessions and enable her to leave the house when she withdrew her consent.

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Seclusion — adverse comment

233. Ms A said that on an unspecified date she told staff that she was feeling low and admitted feeling suicidal. She was taken into the room usually used for counselling, where the staff instructed her to take some medication and told her that her doctor had provided it. Ms A refused to take the medication. She told HDC that she was pressured repeatedly by staff to take the medication and, because she refused to take it, she was kept in the counselling room and not allowed back into the rest of the house. She was told that the reason was to avoid triggering the other residents.

234. Ms A said that there was a bed in the counselling room, and she was kept in the room for a 'long period' of time, during which staff would visit her periodically to pressure her to take the medication, using threats of Police involvement and sectioning under the Mental Health Act. Ms A said that Ms E came into the room with Ms A's mother on the phone, and when her mother, who was crying, asked her to take the medication and to 'trust the professionals', she took the offered medication.

235. In response to the provisional opinion, the facility said that the reason Ms A was in the counselling room was to make her comfortable. The facility denied that this was punitive or related to her taking her medication. The facility said that Ms A was not required to stay alone in the counselling room on the night of 25/26 August 2014 but was there willingly at a time when she was distressed and feeling nauseous.

236. Ms A stated that when she was taken back to the house from hospital on 1 September 2014, again she was put in the counselling room alone, where she remained for two more days. She said that she asked to leave a few times and, eventually, staff asked her if she would pray for forgiveness, and then she could re-join the rest of the girls. She said she did so because she did not want to remain in the little room and wanted other people to talk to. In response to the provisional opinion, the facility noted that there is no evidence that Ms A was asked to 'pray for forgiveness'.

237. The facility agreed that Ms A spent the night of 25/26 August 2014 in the counselling room but said that it was used the next day for counselling sessions, so she could not have stayed there for a longer period, and the records show that she went for a walk offsite the next day. The DHB1 records state that at 2.46pm on 26 August 2014 Ms E spoke to the nurse and told her that Ms A had remained in bed for most of the morning and appeared to have slept well.

238. The facility said that when Ms A returned to the house on 1 September 2014, she re-engaged with the programme, but around 4pm she reported to staff that she was having hallucinations. At that point she was again taken to the counselling room, where she responded well to staff assurances of her safety and engaged in grounding exercises. She was then taken to the ED (on the advice of the Crisis Team), and the facility said that on her return, she went to her usual room. The facility has provided no records of the length of time Ms A spent in the counselling room, or the reason for that, or whether she was permitted to leave.

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239. I find that Ms A believed that she was required to stay alone in the counselling room on 25/26 August 2014. However, due to the conflicting accounts and lack of written records, I am unable to make a finding as to whether she was returned to the counselling room on 1 September 2014 after having been seen at the ED.

240. The New Zealand standard 'Health and Disability Services (Restraint Minimisation and Safe Practice) Standards' NZS 8134.2:2008 (the NZDS Restraint Standards) provides that seclusion is a form of restraint and it should not be used as a component of a consumer's service delivery plan to modify unwanted behaviour. Seclusion may be used only to manage safety, and it is not to be used by providers for punitive reasons or as a routine measure; it is 'a serious intervention of last resort requiring robust clinical justification and oversight'. The standard states that any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. The standard requires organisations to develop clear policies and procedures to guide service providers in the implementation of the standard and seek legal advice if necessary. It also requires that organisations document 'individual consumer restraint minimisation and safe practice assessments and evaluations including the clinical rationale for restraint use and the impact of restraint use'. Despite the requirements of the NZDS Restraint Standards, the facility has provided no policies or procedures regarding its use of seclusion. In response, the facility said that as it has never used seclusion or restraint procedures, there are no policies regarding this.

241. There are also no records with respect to the clinical rationale for Ms A remaining in the counselling room on 25/26 August 2014, or any ongoing assessments of Ms A while she remained there. Although there is reference in the documentation to Ms A expressing suicidal ideation, there is no documented evidence that the rationale for Ms A being in the counselling room was to protect her safety, and I note Mr Hanton's comment that there was inadequate documentation with respect to the suicidal ideation expressed on 25 August. Ms A has not asserted that the room was locked, and the facility explained in response to the provisional opinion that the counselling door is unable to be locked from the outside. However, I accept that Ms A believed she was not permitted to leave. I am particularly concerned that the records do not refer to the length of time she was in the room or the reason for this. On the evidence before me, it is therefore unclear whether Ms A was secluded in the counselling room and, if she was, that the seclusion was used as a last resort in order to manage her safety or to manage the safety of those around her.

Accordingly, due to the lack of evidence, I cannot make a finding on whether the facility's treatment of Ms A was consistent with the NZDS Restraint Standards. However, I am critical that staff did not appear to have a clear understanding of restraint standards, and nor did the service have a policy on seclusion and restraint. I note the facility's submission that it did not use seclusion and restraint. However, in a residential treatment environment, it is important that staff understand what constitutes restraint and seclusion, and in what circumstances these may be used. This is illustrated by the fact that Ms A felt that she could not leave the counselling room.

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Privacy — adverse comment

242. I am concerned to note that the DHB1 record of 2 September 2014 states that it was 'a counselling prerequisite' for Ms A's counsellor to read her journal. In response to the provisional opinion, the facility stated that it was not a counselling prerequisite for Ms A's counsellor to read her journal. The facility said that residents were invited to share their journals if that was deemed to be helpful in the counselling relationship. The facility also stated that '[i]t would be reasonable for a request to be made if there were concerns around safety'.

243. I accept that journalling is an accepted component of this treatment programme, but it should be made explicit to consumers how this may be used in the course of treatment, and with whom they would be expected to share the journal. Doing so would allow consumers to decide on the information they consent to share. In my opinion, Ms A was not sufficiently aware that she would be required to share her journal with her counsellor, and Ms A felt coerced into sharing her private information in order to receive counselling services at the facility. I consider that this was an unwarranted invasion of privacy. I also note that standard 1.3.1 of the NZHDSS states: 'The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.' I am concerned that the facility was not meeting this standard.

Telephone call to Ms A's mother — other comment

244. Mr Hanton identified a departure from the standard of care in respect of Ms A's complaint that the facility called her mother on the evening she tried to leave the house. He advised: 'It was for [Ms A] to determine whānau contact, and this is clearly a step away from whānau-centred care and [Ms A's] wishes have been lost here.'

245. As discussed above, there is a dispute of fact over whether Ms A's mother was called at the request of Ms A, or on the instigation of Ms L. I do not find that the facility breached the Code in this respect, but I draw the facility's attention to Mr Hanton's comments and remind the facility that it is for the consumer to determine when to contact whānau.

Opinion: Ms J — adverse comment

246. Ms J was Ms A's counsellor. She was registered with NZCCA at the relevant time.

247. Ms A had experienced sexual abuse. She said that Ms J discussed with her the concept of 'soul ties', in which God intends sex only for marriage, and that sex tears and binds two souls together, including non-consensual sexual contact. Ms A said that Ms J asked her to write a list of all her sexual partners, including all sexual contact and not just intercourse, so that they could break the soul ties.

248. Ms J said that there is nothing recorded in her counselling reports that points to her having instructed Ms A to write a list of sexual partners.

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249. The facility said that co-dependency was explored in the counselling sessions, although never with the use of the term 'soul ties'. However, Ms A's Counselling Reports written by Ms J show that three months into her programme Ms A 'chose to pray some prayers of forgiveness, sexual soul ties and to break ties with the occult'.

250. Ms A's sexual abuse and her abuser were discussed over two sessions with Ms J — on 21 July 2014 and 28 July 2014. Ms J stated that she would not instigate this type of interaction unless it was therapeutically indicated. She said that during the session on 21 July 2014, she prayed 'to sever the ties to the man who raped [Ms A]'. She stated that this would have been a result of what was discussed in the session, given that trauma impacts the whole person, ie, the body, soul (which is the mind and emotions), and spirit.

251. Ms J said that it is a commonly held Christian belief that the act of sex involves a spiritual component. However, she said that she did not infer or say explicitly that 'all sexual contact breaks your soul and ties them to you, including non-consensual assault' or that 'God would bind [Ms A's] soul to that of [her] abuser'. She stated that she prayed with the intention of negating any fear that Ms A may have had that the abuser still had a controlling influence on her life. Ms J stated:

> 'The use of the phrase "soul ties" is not a terminology that I currently use in my practice nor has been for several years, owing to regular development and evaluation of my professional practice and taking into account Christian societal shifts.'

252. I am unable to make a finding as to whether Ms J asked Ms A to write a list of her sexual partners, but I find it more likely than not that the *concept* of soul ties was included in the counselling, and that it included ties to the perpetrator of non-consensual sexual contact.

253. Regarding the concept of 'soul ties' used in counselling, Mr Hanton advised:

> '[I]t is certainly not something I would see as an appropriate use of terminology or concept in any therapeutic model that I am aware of. I found this whole area to be inadequately explained and if [Ms A] is correct, then it is oppressive and discriminatory regarding a resident's sexuality and freedom to express that. My findings here are that if [Ms J] did use this phrase and/or concept she strayed from the role of the therapist and became an influencer and that the therapeutic relationship strayed from being one of trust on behalf of [Ms A], this is a serious departure of accepted therapeutic standards.'

254. The facility agreed with Mr Hanton. It said that if the therapeutic relationship was as Ms A described, it would have been oppressive and discriminatory. The facility also told HDC: '[We] respect all participants' right to freely express their sexuality without fear of discrimination or judgement; this has always been our intention and is consistent with our values.'

255. The phrase 'soul ties' was included in the counselling provided by Ms J to Ms A. However, based on the information before me, I cannot make a finding about how the term was explained to Ms A.

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256. Given that I have been unable to establish how the term was explained, and given the passage of time (10 years) since these events, I do not consider that I can find Ms J in breach of the Code. However, I agree with Mr Hanton's criticism that this is not an appropriate use of terminology in any therapeutic model and am critical of Ms J's actions in using the term in the course of providing counselling services.

Opinion: Care of Ms B

Medical treatment — breach

Blood test results

257. Ms B had a history of purging, which caused abnormal blood test results. At times Ms B had low potassium levels, and she was aware of the potential health risks of this, as previously she had been hospitalised when her potassium levels were low.

258. On Friday 25 April 2014 Ms B's blood test showed that her bicarbonate level was high at 34mmol/L (normal 22–31mmol/L), and her phosphate level was high at 1.9mmol/L (normal 0.7–1.5mmol/L). Dr K talked to Ms D, who said that Ms B was 'OK'. Dr K was unsure of the significance of the abnormal results but, as Ms B was well, and as the facility did not have full staff on weekends, Dr K and Ms D decided that Ms B would not be informed of the results that day and Ms D would talk to her on the following Monday. Ms D is not qualified clinically and is responsible for the financial, HR, administration, and fundraising at the facility.

259. The facility has provided no evidence that Ms B consented to having her test results provided to staff rather than to her. Right 6(1)(f) of the Code states that consumers have the right to be informed about the results of tests. In my view, Ms D should not have taken the responsibility of discussing Ms B's abnormal results with Dr K. Dr K should have informed Ms B of her condition (and I discuss Dr K's responsibility in this respect in more detail below), and Ms D should have facilitated this at the first reasonable opportunity.

260. On 30 April 2014 Ms B's blood test results showed low sodium, very low potassium, and high bicarbonate. Dr K contacted Ms M because of her concern about the low potassium level. Dr K spoke to a medical registrar, who suggested prescribing Chlorvescent initially, followed by three days of Span-K daily. Ms M told Dr K that Ms B seemed 'ok'. There is no record of any assessment of Ms B. I am concerned that Ms M, whose training was in psychology, did not have the expertise to assess Ms B and conclude that she was 'OK'.

261. In response to the provisional opinion, the facility stated that its staff were being asked for an observation rather than a medical assessment of Ms B. The facility said that Ms B was involved in the discussions around her health care on the evening when the GP consulted with the hospital specialist for advice regarding Ms B's results. The facility stated that while Ms B did not speak with the GP directly when the GP phoned to discuss the script, the staff member was speaking with Ms B and letting her know the blood test results. Ms

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B accompanied the staff member to the pharmacy, during which time there were further discussions.

262. Dr K told Ms M that Ms B could stay at the house that night provided she took the Chlorvescent. Dr K faxed a script to a pharmacy so that staff could pick up the medication.

263. Ms B believes that she should have gone to hospital. She said that she had no say about this as staff took the call, then they called her into the office and told her the decision. She stated that she would have been pleased to go to hospital because, as well as being safer, it would have got her out of the house. However, she said that she was not consulted about the decision. The facility stated that Ms B did not ask to go to hospital.

264. On 1 May 2014 Dr K emailed the facility that Ms B's blood test results the previous day had shown a very low potassium level of 2.5mmol/L. There is no indication that this email was copied to Ms B or that she was otherwise informed of this result. Again, I am critical of the failure to keep Ms B informed. In response, the facility agreed that test results given via the phone were not always given to Ms B immediately, but it asserted that the email results addressed to Ms B were given in a timely manner.

Administration of diazepam

265. Ms B stated that she was prescribed diazepam for alcohol withdrawal but, rather than assessing her for withdrawal symptoms, the staff would simply ask if she wanted diazepam. My inhouse clinical advisor, GP Dr David Maplesden, advised that the PRN use of diazepam for the purpose of assisting detoxification was not indicated or appropriate, nor was it appropriate to use diazepam on a PRN basis in this context, without formal assessment of withdrawal symptoms. He stated:

> 'I would be moderately critical if the diazepam was being used in this context although that criticism might apply primarily to the prescriber if [the facility] were simply following the medication label instructions.'

266. It appears that Ms B took the diazepam to the facility when she was admitted, and it was held by the facility and administered by staff. The Medicine Overview Chart dated 9 April 2014 lists diazepam as one of Ms B's medications and states: 'Take l x 2mg tablet as required for alcohol withdrawal.' Given the failure by the facility to retain medication records, it is not possible to verify how frequently the medication was administered or the reasons for the administration, while Ms B was there. However, noting that the facility has not denied that its staff gave Ms B diazepam, I accept that Ms B was given diazepam on at least one occasion by staff.

267. In response to the provisional opinion, the facility confirmed that it did not medically assess alcohol withdrawal symptoms as a reason for administering diazepam. It said that the assessment was made by Ms B's medical team prior to coming into the home. The facility stated:

> 'If we did dispense Diazepam, it would have been at [Ms B's] request and our staff would have followed the instructions on the medication. We accept that we have not

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kept the medication records for the few days [of] medication [that] had been prescribed.'

268. I note Dr Maplesden's advice that there should be a formal assessment of withdrawal symptoms before diazepam is given on a PRN basis. On the evidence before me, it appears that none of the staff were appropriately trained to undertake an assessment of withdrawal symptoms. Accordingly, I am very critical that the facility gave Ms B this medication.

Communication with GP

269. Dr Maplesden commented that he would expect all details of Ms B's regular and PRN medication use to have been provided to Dr K at the time of Ms B's registration and/or first GP assessment, but the only mention of diazepam in the GP notes is of Ms B's previous (rather than current) use. I agree and I am critical that Dr K was not provided with an accurate record of the medications being administered to Ms B by staff.

Conclusion

270. I am concerned that staff who did not have appropriate clinical qualifications drew conclusions about Ms B's medical condition. In addition, Ms B was not given the opportunity to be a partner in her own health care. Right 6(1) of the Code states that every consumer has the right to an explanation of their condition, the results of tests, and the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option. In my view, Ms B should have been informed of the test results and given the opportunity to participate in the decision-making regarding her care, particularly whether hospital admission was indicated. Accordingly, I find that the facility breached Right 6(1) of the Code.

Opinion: Dr K — adverse comment

271. On 25 April 2014 Ms B's blood test showed that her bicarbonate and phosphate levels were high. Dr K was unsure about the significance of the abnormal results and talked to Ms D about the results, sought Ms D's view on whether Ms B was well, and asked whether the results should be discussed with Ms B. Ms D said that Ms B was 'OK'. Dr K noted that as Ms B was well, and as the facility did not have full staff on weekends, she and Ms D elected not to 'confront' Ms B that day, and Ms D would talk to her on the following Monday.

272. Ms D is not clinically trained and so was not adequately skilled to assess Ms B's health appropriately. Ms D is responsible for the financial, HR, administration, and fundraising at the facility. I am concerned that Dr K accepted Ms D's assessment of Ms B's condition.

273. There is no evidence that Dr K confirmed that Ms B had consented to discussion of her results with staff. Ms B had signed a Medical and Property Release Agreement that authorised the facility to release information and to obtain appropriate medical, social,

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educational, psychological, dental, and/or other services as the facility deemed appropriate. Dr K does not recall having seen this form and there is no record of the form having been provided to her. Furthermore, there is no record that Ms B had consented to Dr K discussing her results with staff rather than with her.

274. Dr Maplesden advised that the abnormalities noted in Ms B's blood tests were likely to be related to her eating disorder (although low rather than elevated phosphate is more commonly found in this condition), and in an otherwise well patient the results were not of immediate concern. He said that Dr K was conscientious in seeking further expert advice regarding the results, and the plan to repeat the tests in a few days' time was appropriate in the circumstances.

275. However, Dr Maplesden said that if Ms B had not given consent, it was inappropriate for Dr K to discuss her results with anyone other than with Ms B directly, although it was reasonable for Dr K to question staff initially regarding their impression of Ms B's current wellness. Dr Maplesden stated that it would be expected that abnormal results would be discussed with the patient in a timely manner but, as Ms B was apparently well, it was reasonable to defer such discussion until after the weekend when there was a full complement of staff to support Ms B if required. He said that discussion should have been undertaken directly by Dr K unless it was confirmed that Ms B had consented to her health information being discussed with staff.

276. Right 6(1)(f) of the Code states that consumers have the right to be informed about the results of tests. In my view, Dr K should have informed Ms B directly of her test results and their significance, and I am critical that she did not do so.

277. On 30 April 2014 Ms B's blood test results showed low sodium, very low potassium at 2.5mmol/L, and high bicarbonate. Dr K was concerned about Ms B's low potassium level and contacted Ms M. Ms M did not have clinical qualifications, but she said that Ms B seemed 'ok'. Dr K also spoke to a medical registrar, who suggested prescribing Chlorvescent initially, followed by three days of Span-K daily.

278. Dr K told Ms M that she was 'ok' with Ms B staying in the home that night provided she took the Chlorvescent. Dr K faxed a script to a pharmacy so that staff could pick up the medication. On 1 May 2014 Dr K emailed the facility that Ms B's blood test results the previous day had shown a very low potassium level of 2.5mmol/L. There is no indication that this email was copied to Ms B or that Dr K discussed the contents with her.

279. Ms B believes that she should have gone to hospital, but she said she had no say about this because staff took the call, and she did not have the opportunity to speak to Dr K. Ms B said that the staff member called her into the office and told her the decision, and she was not asked whether she felt that she should go to the hospital.

280. In response to the provisional opinion, Dr K said that this is not always a decision that patients can make. Dr K stated that she had confidence that the providers at the facility would have picked up a mental health situation that would need hospitalisation, in

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particular suicidal ideation. She had also been reassured by the hospital doctors with whom she spoke that there was no medical indication for admission, based on Ms B's results at that time.

281. Dr Maplesden advised that best practice would have been to arrange a physical assessment of Ms B on 30 April 2014 when the blood results were first known. He stated:

> 'However, I note [Dr K] was acting on expert advice and had received verbal reassurance from staff that [Ms B] was apparently well although I understand the staff involved were not trained nurses, and the extent of any formal physical assessment at this time appears very limited. If [Dr K] was aware the staff involved in assessing [Ms B's] wellbeing on the evening of 30 April 2014 were not clinically trained, I would be mildly critical she did not arrange a clinical assessment of [Ms B] at that time (although I am unable to exclude the possibility that the medical registrar declined a suggestion or request for ED assessment).'

282. Dr Maplesden was also mildly critical that Dr K did not arrange a face-to-face assessment of Ms B on 1 May 2014. In response, Dr K said that she saw Ms B in person on 2 May 2014, at which time she examined her, discussed the results, and arranged on-going monitoring.

283. In my view, Dr K should have assessed Ms B on 24 April and 30 April 2014 (noting that staff were not appropriately qualified to undertake such an assessment) or 1 May 2014 and ascertained whether it was appropriate for her to remain in the house. Dr K should also have informed Ms B of her test results and discussed her management with her. I am left with the impression that Dr K failed to acknowledge her clinical relationship with Ms B adequately and instead communicated with staff.

Changes made

284. Since the events described in this report, the facility has ceased providing a residential programme. The facility told HDC that it has now changed to an online services model and has no plans to return to providing a residential programme.

285. The facility told HDC that between the events described in this report and the cessation of its residential programme, it made several changes as follows:

a) It was facility policy that even where written consent to receive services existed from a resident, verbal consent would still be sought in the moment.

b) Since the end of 2014, the facility logged enquiries from social workers and other organisations and individuals, to track the pathway that applicants and their support people take when engaging with the facility.

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c) The facility told HDC that in order to address misunderstandings about what its programme provides, it ensured that its responses to enquiries were as thorough as possible.

d) The facility told HDC that to ensure that its programme was right for an individual, it made more thorough enquiries about residents' health, support, and risk factors.

e) The 30- and 60-Day Commitment forms were removed from the application pack and the Standards Agreement and Programme Expectations were redrafted.

f) The facility discontinued the Resident Handbook, as it was regarded by residents as a rule book contrary to the facility's intentions. The topics were covered in emails and discussions with residents and their whānau.

g) The Staff and Volunteer Handbook/Standard Operating Procedures was rewritten. Several relevant changes were made, including the following:

   i. Residents' emails from their support people were not to be read by staff. Where a resident proceeded to 'skill strengthening' following a 30-day review, she might be allowed to use her own mobile phone to send emails at the weekend, though some residents still chose to use the central email hub;

   ii. Where a resident proceeded to 'skill strengthening', she might use her mobile phone at weekends during call allocation time to contact support people;

   iii. The provisions relating to GP visits were rewritten; and

   iv. There was a full process for exits from the programme recorded in the Staff Guide as follows:

   'Exit from Programme: Process

   Exits are handled by the Day Team and at least 24 hours is needed to:

   - Refer Check-Out of Resident's document for full process.
   - Ensure that the Resident's risk has been assessed and appropriately addressed with a Safety Plan and handover if necessary.
   - Ensure that travel arrangements are secured.
   - Balance and prepare Medication for return to Resident.
   - Balance and prepare Cash for return to Resident.
   - Ensure that all personal belongings (including valuables that are kept safe and locked away in the Office) have been retrieved and signed for by Resident.'

h) The practice of redacting newspapers ceased. Staff also facilitated requests from residents who liked to catch up on news, and important updates regarding key events were printed daily for residents.

i) The facility used a streaming service for movies, and residents voted on movies to watch for the weekend.

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j) Rather than a generalised Residential Programme Overview document, the facility used an individualised treatment plan.

Recommendations

Facility

286. I recommend that the facility provide separate written apologies to Ms A and Ms B for the criticisms contained in this report. The apologies are to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A and Ms B.

287. I recommend that within three months of the date of this report, the facility arrange for all staff to complete HDC's online learning Module 1 (How the Code of Rights improves health and disability services) and Module 3 (Complaints management and early resolution) and provide evidence of completion to HDC.

288. The following recommendations apply if at any point the facility intends to recommence its residential programme:

a) Before doing so, arrange an inspection by HealthCERT to determine whether it requires certification pursuant to the Health and Disability Services (Safety) Act 2001 and report to HDC on the results, within three months of receiving the results of the inspection.

b) If, following any such inspection, it does require certification pursuant to the Health and Disability Services (Safety) Act 2001, take all necessary steps to obtain that certification and report to HDC on the progress of its application, within three months of making the application.

c) Set up processes to ensure that adequate records are maintained in accordance with the Health (Retention of Health Information) Regulations 1996 and report to HDC before recommencing a residential programme.

d) Display a copy of the Code in a prominent location at any facility where it provides health services, and on its website, and confirm to HDC that this has been done within three weeks of the date of this report.

e) Ensure that the qualifications of staff are made clear to consumers, including whether those with nursing training are registered nurses, and confirm that this has been done, with evidence, within three weeks of the date of this report.

f) Ensure that staff accompany residents to medical appointments only with specific consent, which is recorded in each case, and that residents are free to refuse consent with no adverse consequences, and report to HDC before recommencing a residential programme.

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g) Develop policies regarding residents' participation in their own health care, including that all test results are provided to them, and report to HDC before recommencing a residential programme.

h) Refresh its Resident Handbook with the Ngā Paerewa Health and Disability Services Standard (2021) in mind and provide a copy of the new Resident Handbook to HDC before recommencing a residential programme.

i) Set up processes to enable residents to withdraw their consent to services at any time and to leave the facility if they wish to do so.

j) Report on any further changes implemented as a result of this report, within three months of the date of this report.

Ms J

289. I recommend that Ms J provide an apology to Ms A for the criticisms contained in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

Dr K

290. I understand that currently Dr K is not practising. Should Dr K decide to return to practice, I recommend that she complete HDC's three online learning modules for providers and provide HDC with evidence of completion.

Follow-up action

291. A copy of this report with details identifying the parties removed, except the advisors, will be sent to NZCCA and HealthCERT and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Mr Paul Hanton:

'**Review of Complaint [Ms A]. 9th March 2023.**

Author. Paul Hanton.

The author has worked in the drug and alcohol field for over 30 years, at various levels in different roles, including as a clinical manager in a prison based Therapeutic Community, and as a CEO of a 20-bed residential unit. The author is a registered and accredited therapist and clinical supervisor.

I Paul Hanton confirm that I have read all the documentation sent to me by the HDC. I have arranged my feedback in four sections:

Section 1. Review of documentation (including discrepancies and "questions")

Section 2. Findings relating to practice

Section 3. Recommendations

Section 4. Response from [the facility], December 2022.

I note that Health and Disability Services Standards — Health and Disability Services (core) Standards were in place from 2008 and that "residential addiction, mental health, and disability services need to meet the requirements of NZS 8134.1:2008", and this would include [the facility]; though they may not have been audited against these standards, nor had specific training in these. It would be expected however that services and peers in this sector would align to and adhere to these. These Service Standards are still available from

https://www.standards.govt.nz/shop/nzs-8134-12008/

In my recommendations I will refer for the need for [the facility] to align practices, policies and procedures to Ngā Paerewa (superceded NZS 8134.1:2008 in 2022) if continuing to operate. In my findings I will refer also to Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

Summary:

It is my professional opinion that [the facility] provided a service based on current practice at the time, though not "best practice".

[The facility] [was] influenced by their Christian values or interpretations of those values, more than the Health and disability services Standards.

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There were, in my opinion, failings which could be set against the Service Standards and HDC rights framework, the latter which had been in place for nearly a decade and would be well known to services.

All services in the mental health and addictions sector will at times, fall short of their own and external standards and need to be comfortable with the practices of open disclosure and learning from feedback. I am not sure, from reviewing the responses from [the facility] that they see a complaint as an opportunity to improve practice, and any response from HDC will need to be supportive in this area to enable improvements.

Section 1. Review of documentation.

Whilst the documentation is considerable, I found there to be a lack of consistency and depth, and clearly different narratives of events from the viewpoint of [Ms A] and [the facility]. Some examples of this are around medication given to [Ms A] that is not well documented, and in particular her assertion that she tried to leave on October 20th, there are more.

The handover notes that are provided are poor in parts and detail events from one viewpoint ([the facility]) with little reference to the tāngata whaiora narrative. It is my opinion that documentation was not complete, nor accurately reflected [Ms A's] views or accounts; this would not be an acceptable level of documentation in many rehabilitation services, I feel my peers would agree that this is a moderate departure from what would be the expected standard.

The response from [the facility] to [Ms A] (17th November 2020) "feels" defensive and at points patronising and almost gaslighting. There is little acknowledgment of [Ms A's] complaint or concerns, rather it is a list of counter arguments. It would have been good to see a bit more understanding and compassion.

NB: As a postscript to my original advice sent to [the facility] by [HDC] a response was received (dated 23rd December 2022) from [Ms D], executive director. So as not to unduly alter my original findings, which I stand by, I will address this response in a final paragraph.

Section 2. Findings related to practice.

I note the events and issues detailed by [Ms A] which, in the most part highlight standard practice. Some examples of this:

- Opening letters in front of staff, this would be carried out in most rehabs as letters could contain drugs or other contraband, letters are not read by staff, and this was not alleged here.
- No TV is standard practice, particularly in junior phases of programmes, so as not to have residents distracted from the programme.

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- Ensuring that any particular two (or more) residents do not become too close or "pair off"; rationale for this is that exclusive relationships do not dominate a community setting.
- Room searches after a resident has been caught using; again standard practice.
- I find no evidence of coercion by the Social worker regarding the mental health act.

I found the cutting up of newspapers odd, but not in any way abusive or harmful. My findings here are consistent with accepted practice in therapeutic communities.

Potential failings:

- The issue relating to "soul ties".

Whilst [Ms J] denies this in the therapeutic relationship, she goes on to state that it is something she no longer uses, which seems at the least contradictory in my opinion. I have not seen [Ms J's] qualifications, but it is certainly not something I would see as an appropriate use of terminology or concept in any therapeutic model that I am aware of.

I found this whole area to be inadequately explained and if [Ms A] is correct, then it is oppressive and discriminatory regarding a resident's sexuality and freedom to express that. My findings here are that if [Ms J] did use this phrase and/or concept she strayed from the role of the therapist and became an influencer and that the therapeutic relationship strayed from being one of trust on behalf of [Ms A], this is a serious departure of accepted therapeutic standards.

- The documentation around the medication, the suicidal ideation (25th August), and request to leave (20th October) is found wanting.

In particular the "filing rules" that [the facility] quote seem to contravene best practice; I understand that medication records should be kept for 10 years; this is a moderate departure from accepted standards.

- There is not enough clear evidence of client led treatment goals or reviews, an expectation and necessity in all MH and Addiction treatment. Moderate departure from accepted standards.
- There is no evidence of staff reviews, team debriefs or any other form of reflection and learning from events recalled by [Ms A]. This is a serious departure from an expectation of continuous improvement and clinical governance.
- At times it appears (though cannot be proved) that faith-based interventions dominate over sector accepted practice. This is not in and of itself cause for concern if set out from before people enter the rehab, and it was.

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- There may have been coercion in terms of keeping [Ms A] in the premises when she expressed a desire to leave. If this is proven it is a serious departure from standards.

The lack of adequate note taking and documentation of staff reviews, debriefs and clinical meetings concern me as this is a moderate departure from expected standards within a setting of this type.

- [Ms A's] mother appears to have been communicated to as a staff decision, not [Ms A's] "We continue to include her … at no stage …"

It was for [Ms A] to determine whānau contact, and this is clearly a step away from whānau centered care and [Ms A's] wishes have been lost here. This is not acceptable in terms of trust building and putting the client at the centre of care and is a severe departure from accepted standards that my peers in this field would agree with.

Section 3. Recommendations

Recommendation 1.

I see no evidence of audits and as a registered residential centre these are required every three years and corrective actions need to be carried out.

Therefore:

Immediate audit against Ngā Paerewa is required and corrective actions to be carried out as needed.

Recommendation 2.

I note that [the facility] wishes to write a letter of apology to [Ms A]. I am concerned that this may not align with their denial of any wrongdoing, though welcome it and would suggest that a user advocate help them. This letter should also outline the actions that [the facility] are undertaking to avoid a similar situation, such as audit.

Therefore:

Letter of apology, person centered.

Recommendation 3.

I see no evidence of collaborative goal planning, reviews or plans of any kind between [Ms A] and staff.

Therefore:

There needs to be clear evidence of collaboration in the processes at [the facility] from this point on, this could take place as any, or all of:

- Cosigned treatment plans

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- Individually presented needs, verbally, written or in any other form
- Regular, documented reviews with tāngata whai ora, including areas of disagreement and solutions, with use of peer support and/or advocates if needed or requested

Recommendation 4.

That [the facility] are supported in terms of continuous improvement.

Therefore:

[The facility] should be encouraged to present in any response, a continuous improvement plan including appropriate training in Ngā Paerewa.

Section 4. Response from [Ms D], 23rd December 2023.

I would like to start by saying that this response seems more reflective, measured and conciliatory than that of 17th of November. That the response states that they are keen for feedback and an opportunity to learn sets a good tone.

The mention of a "medical model" in point one is not relevant as the service standards apply to the service, whether they use a medical model or not, however, recognising potential improvement is welcomed. This is followed by an acknowledgement of not best practice at the time, this is also welcomed.

Point 2 is compassionate, recognising that the original response may have been hurtful to [Ms A] and this is a good illustration of the reflection that seems to have taken place.

Point 3, welcomes the opportunity to apologise to [Ms A] and states clearly that she has a right to express her sexuality, this does need to be confirmed in any apology.

Point 4 is noted and acknowledged.

Points 5 & 6 reflect that there was either insufficient documentation, or that this was not presented to the HDC, whether it took place or not. The fact that [the facility] has now moved from a residential model does not lessen the accountability that good documentation brings. I note the continuous improvement.

Point 7 is complex and relies on different accounts of events and whilst the intent explained is clear, I am not convinced that [Ms A] did not feel either coerced, or "trapped". I am not sure of an adequate response here other than to ensure all issues relating to discharge or potential discharge are well recorded, including the views of the resident.

Point 8 reflections are welcomed, though I would point out that staff records containing reviews should be held, particularly if staff are still employed.

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Point 9 is still a matter of disagreement from [Ms A's] point of view.

Point 10. I refer again to Core service standards.

Finally, to address point 11. The offer to apologise fully would be totally appropriate and the assistance of an advocate is essential. It would be important beforehand to ascertain [Ms A's] wishes, she may want a written apology, a meeting, an acknowledgement or something else altogether. It would be wise to discuss the options with [Ms A] before any move from [the facility].

Paul Hanton: BA (Hons), PG Cert (Substance Misuse) MA (Solution Focused Brief Therapy)

DAPAANZ accredited supervisor, MBACP Reg. (Accred)'

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Appendix B: In-house clinical advice to Commissioner

The following in-house advice was obtained from Dr David Maplesden on 11 March 2024:

> '1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a vocationally registered general practitioner holding a current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her while she was a resident of [the facility] [the facility] in 2014. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> 2. I have reviewed the following information:
>
> Complaint from [Ms B]
>
> GP notes [medical centre]
>
> Response from [Ms D], Executive Director, [the facility]
>
> Limited care notes and policy documents [the facility]
>
> Clinical notes [DHB1]
>
> HDC file summary (not reiterated here) with questions as presented below (bold)
>
> 3. **Please advise whether the management of [Ms B's] bicarbonate, phosphate, sodium, and potassium levels by [Dr K] was appropriate.**
>
> (i) GP notes indicate [Ms B] ([year of birth]) registered with [the medical centre] on 16 April 2014. History of previous generalised anxiety disorder, eating disorder (bulimia) and alcohol abuse is noted. Regular medications noted on the registration form were Span K (potassium supplement) and thiamine. Consult notes dated 23 April 2014 ([Dr K]) refer to history of hypokalaemia (low potassium) *as low as 1.4* (reference range 3.5–5.2 mmol/L) … *but when arrived was normal.* Further medication history of previous (not current) diazepam use is noted together with recent fluoxetine use (*stopped taking 2 months ago … feels less happy since off Fluox*) and citalopram trial prior to fluoxetine. Current omeprazole and loratidine use is noted and lactulose was prescribed for constipation symptom. Blood tests performed on 24 April 2014 showed elevated phosphate and calcium levels (normal albumin), reduced ferritin, mildly elevated bicarbonate (34.0, reference range 22.0–31.0 mmol/L) and normal electrolytes and renal function. [Dr K] has annotated the bicarbonate result as *may be purging.* On 25 April 2014 [Dr K] has documented speaking with staff regarding [Ms B's] current wellbeing (normal) and attempting to consult with the on-call medical registrar and laboratory biochemist regarding the likely significance of the results, together with undertaking her own research. [Dr K] was eventually reassured by a laboratory biochemist that the results should normalise if related to recent ingestion and vomiting. There was further discussion between [Dr K] and staff with the

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comment recorded: *As* [Ms B] *is well, and not full staff at [the facility] on weekend, elected together with* [staff member] *not to confront her today.* [Staff member] *will talk to her Monday, suggest (if remains well) bloods on Thursday 1 May, see Friday.*

Comment: The abnormalities noted in [Ms B's] blood tests were likely to be related to her eating disorder (although low rather than elevated phosphate is more commonly found in this condition) and in an otherwise well patient the results were not of immediate concern. [Dr K] was conscientious in seeking further expert advice regarding the results and the plan to repeat the tests in a few days was appropriate under the circumstances. If [Dr K] confirmed [Ms B] had consented to discussion of her results with staff, then it was reasonable to undertake such a discussion. If there was no such consent, it was inappropriate for [Dr K] to discuss the results with other than [Ms B] directly although I believe it was reasonable for [Dr K] to question staff initially regarding their impression of [Ms B's] current wellness. It would be expected that abnormal results are discussed with the patient in a timely manner and noting [Ms B] was apparently well I believe it was reasonable to defer such discussion until after the weekend when there was a full complement of staff to support [Ms B] if required. Again, this discussion should have been undertaken directly by [Dr K] unless it was confirmed [Ms B] had consented to her health information being discussed with staff.

(ii) Blood tests were repeated on 30 April 2014 (Wednesday). Calcium and phosphate levels had normalised but results now showed decreased serum level of sodium (130, reference range 135–145 mmol/L) and potassium (2.5, reference range 3.5–4.2 mmol/L) with raised bicarbonate at 38 mmol/L (likely related to hypokalaemia and purging/vomiting) and slightly reduced serum osmolality (likely related to excessive water intake). [Dr K] discussed the results with the laboratory pathologist that evening (bicarbonate not dangerous, hypokalaemia could be symptomatic). She then checked with staff regarding [Ms B's] wellbeing (*seems OK*) and discussed the situation with the medical registrar on-call with advice recorded as: *suggests faster absorbing K in form of Chlorves 3 stat, from then on 3 Span K x tds (9 daily) x 3 days … Phone to Shorecare Pharmacy.* [Dr K] reviewed [Ms B] on 2 May 2014 noting ongoing (but pre-existing) symptomatic postural hypotension and normal pulse. Plan was for *regular blood tests, twice weekly x 3 weeks elec, bicarb then see.* Results dated 2 May 2014 showed electrolytes had returned to normal with ongoing modest rise in bicarbonate (in the clinical context described most likely related to metabolic alkalosis secondary to recent hypokalaemia and vomiting/ purging). Subsequent results (to 3 July 2014) showed maintenance of normal electrolyte balance with bicarbonate remaining around or just over the upper limit of normal.

Comment: [Ms B] had a previous history of hypokalaemia related to her eating disorder and the drop in potassium noted on 20 April 2014 was most likely related to a recent purging/vomiting episode coupled with excessive water intake, with bicarbonate levels also linked to the hypokalaemia. The potassium level of 2.5 is regarded as borderline for seeking hospital admission (admission recommended if

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level less than 2.5[1]) with the cited reference noting (for patients with acute hypokalemia): *Assess for signs and symptoms. If cardiac or significant CNS symptoms are present, urgent transfer to hospital is indicated. In moderate hypokalaemia (2.5–3.0 mmol/L), the need for referral will depend upon individual patient circumstances. A suggested approach is to check for the presence of symptoms, consider an ECG and arrange a repeat blood test (same day/next day).* I believe [Dr K] was conscientious in seeking expert advice on 30 April 2014 and it appears she followed this advice. I believe best practice would be to have arranged a physical assessment of [Ms B] on 30 April 2014 when the blood results were first known. However, I note [Dr K] was acting on expert advice and had received verbal reassurance from staff that [Ms B] was apparently well although I understand the staff involved were not trained nurses, and the extent of any formal physical assessment at this time appears very limited. If [Dr K] was aware the staff involved in assessing [Ms B's] wellbeing on the evening of 30 April 2014 were not clinically trained, I would be mildly critical she did not arrange a clinical assessment of [Ms B] at that time (although I am unable to exclude the possibility that the medical registrar declined a suggestion or request for ED assessment). Given the decision not to arrange assessment of [Ms B] on 30 April 2014, I am mildly critical a face-to-face assessment was not arranged by [Dr K] for 1 May 2014 although I note there had been an increase in potassium supplementation (per expert advice) in the interim and [Ms B] apparently remained well. If the on-call medical registrar offered [Ms B] an assessment in ED or hospital admission as a management option during the discussion with [Dr K] on 30 April 2014 (and this is not necessarily the case), I would be mildly to moderately critical if this option was not provided to [Ms B] to consider. The [the facility] documentation suggests [Ms B] was kept well informed of her blood results and management recommended by [Dr K] on 30 April 2014, but the comments in the section above regarding consent to discussion of health information with a third party apply to this section also.

(iii) The comments above are made without a response from [Dr K] and it is possible the comments may require revising if [Dr K] provided additional relevant information regarding her management decisions.

4. **Please advise whether the management of [Ms B's] bicarbonate, phosphate, sodium, and potassium levels at [the facility] was appropriate.**

Staff of [the facility] were primarily responsible for ensuring [Ms B] was taking the medications prescribed by [Dr K] and in undertaking the blood tests ordered by her. I would expect staff to report to [Dr K] any concerns regarding [Ms B's] physical or mental wellbeing, including any ongoing behaviours (excessive fluid intake, purging) that might have contributed to her biochemical abnormalities. I would expect staff to have accurately reported to [Ms B] any advice or comments provided by [Dr K] in relation to [Ms B's] ongoing management. I am unable to determine there was any significant deficiency in these aspects of [Ms B's] management although it is not

[1] BPAC. A primary care approach to sodium and potassium imbalance. Best Tests. September 2011. https://bpac.org.nz/bt/2011/september/imbalance.aspx#5 Accessed 11 March 2024

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entirely clear to me that [Ms B] had granted consent for her medical issues to be discussed by [Dr K] with staff (it is unclear if a copy of the Medical Release form provided in the [facility] documentation was received by [Dr K]).

5. **Please advise whether the management of [Ms B's] Diazepam at [the facility] was appropriate.**

I am unable to confirm details of [Ms B's] diazepam use while in [the facility], including the instructions or documented indication for its use. I would expect all details of [Ms B's] regular and PRN medication use to have been provided to [Dr K] at [the medical centre] at the time of [Ms B's] registration and/or first GP assessment but the only mention of diazepam in the GP notes is previous (rather than current) use. There is no record of GP prescribing of benzodiazepines (including diazepam) while [Ms B] was registered at [the medical centre]. Diazepam is commonly used as part of a formal alcohol withdrawal programme, usually administered in a tapering regime over 5–7 days in the community detox environment or, in an inpatient detox environment, symptom triggered dosing based on CIWA-Ar[2] or similar alcohol withdrawal scale[3]. Diazepam may also be used for management of anxiety as a short-term or PRN medication for acute exacerbations. [Ms B] was not undergoing any formal type of alcohol detoxification programme at [the facility] and PRN use of diazepam for the purposes of assisting detoxification was not indicated or appropriate, nor is it appropriate to use diazepam on a PRN basis in this context without formal assessment of withdrawal symptoms. I would be moderately critical if the diazepam was being used in this context although that criticism might apply primarily to the prescriber if [the facility] were simply following the medication label instructions. If the medication instruction was to use diazepam PRN for anxiety symptoms, and [Ms B] reported anxiety symptoms to staff, it might have been appropriate to administer the medication as prescribed. However, I believe it was important [Dr K] was provided with an accurate record of the medications being administered to [Ms B] by staff and it appears there may have been a deficiency in the process of supplying this information (the relevant [facility] medication management policy recommends providing the GP with a list of medications being administered). The [facility's] process for administering medication and recording the administration appears comprehensive but I have not been provided with [Ms B's] medication administration charts and I am therefore unable to comment on whether the process was followed. Such information would be regarded as a health information which should under normal circumstances be retained for 10 years beginning on the day after the date shown in the health information as the most recent date on which a provider

[2] https://www.mdcalc.com/calc/1736/ciwa-ar-alcohol-withdrawal Accessed 11 March 2024

[3] https://www.dacas.org.au/clinical-resources/gp-factsheets/management-alcohol-withdrawal Accessed 11 March 2024

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provided services to that individual[4] (in this case July 2014). The failure to retain such information, if this is the case, might be grounds for criticism.

6. **Anything else of concern you identify, including whether you feel external EA is necessary.**

I have no additional comment on issues within my scope of practice.'

[4] Health (Retention of Health Information) Regulations 1996 https://www.legislation.govt.nz/regulation/public/1996/0343/latest/DLM225650.html Accessed 11 March 2024

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