

The Mental Health Act and human rights

A discussion document

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Introduction

Purpose

The purpose of this discussion document is to enable interested parties to contribute to a better understanding of:

- the impacts of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ('the Mental Health Act' or 'the Act') on people who experience its application, particularly from a human rights perspective and
- what would improve the opportunities for people who come under the Mental Health Act to have a good life like others.

In particular, this document explores the alignment between the Mental Health Act and our human rights obligations under the New Zealand Bill of Rights Act 1990 (NZBORA) and the Convention on the Rights of People with Disabilities (CRPD).

The discussion document sets out some of the key issues and concerns we are aware of, but we would like to hear from you about your experiences, perspectives and challenges under the Mental Health Act. We are particularly interested in hearing from:

- people who use or have used services under the Mental Health Act
(The term 'tangata whaiora / service user' is used in this document to refer to those who use or have used services under the Mental Health Act. The term 'patient' or 'proposed patient' may also be used when referring to the Mental Health Act, as these are terms used in the Act)
- families and whānau of tangata whaiora / service users, who are also significantly affected when their family member comes under the Mental Health Act
- clinicians and services who treat tangata whaiora / service users under the Mental Health Act
- other individuals or organisations who are involved in administering the Mental Health Act.

Why is the CRPD relevant to people with mental illness?

The description of disability in the CRPD encompasses the human rights of people who have 'long term mental impairments', which is generally understood to include mental ill health or psychosocial disability. The CRPD fosters a new understanding of disability. In the past the focus was on the impairments of people, but the CRPD

widens this understanding to include the barriers faced by people with disabilities, including those with mental ill health (see ‘Defining disability’, page 10).

Context

The work carried out for this discussion document relates to Action 9(d) of the Disability Action Plan:

Explore how the Mental Health (Compulsory Assessment and Treatment) Act 1992 relates to the New Zealand Bill of Rights Act 1990 and the CRPD.

The inclusion of Action 9(d) in the Disability Action Plan responds to concerns of the United Nation’s Committee on the Rights of Persons with Disabilities (‘the ComRPD’) that the Mental Health Act has been criticised for its lack of human rights principles (ComRPD, 2014a).

This work, reflected in the Discussion Document, stems from the oversight provided by the Ministerial Committee on Disability Issues, which oversees the Disability Action Plan and implementation of the CRPD. The findings and recommendations arising out of this Discussion Document will be presented to the Ministerial Committee on Disability Issues in the first half of 2017.

Process and timeline

The Ministerial Committee on Disability Issues asked the Ministry of Health to lead the work. Balance Aotearoa, the Ministry’s partner in this project, advocates for people with mental health and addiction issues and is one of seven disabled people’s organisations that worked with the government on the co-design of the Disability Action Plan. The Ministry has also set up a wider stakeholder reference group, made up of tangata whaiora / service user groups representing family/whānau, academics and clinicians, to advise the Ministry on the key issues. Feedback from a reference group workshop helped informed the development of this discussion document.

The discussion phase for this document runs until Friday, 24 February 2017. The Ministry of Health will continue to consult with key people and organisations in the development of its advice to the Ministerial Committee on Disability Issues.

Scope

Action 9(d) aims to develop a shared understanding of how the Mental Health Act relates to NZBORA and the CRPD (which form part of New Zealand’s human rights framework) and any issues or concerns about its implementation. It addresses issues relating to people who come under the Mental Health Act via the community, rather than those who enter via the forensic mental health service (services for tangata whaiora / service users in the justice system). The development of a new forensic framework is the subject of a separate piece of work.

Action 9(d) is not a review of the Mental Health Act, and changes to the Act are outside the scope of this work. However, the findings will inform any future review of the Mental Health Act.

How you can help

This document highlights our understanding of how the Mental Health Act relates to NZBORA and the CRPD and where we think they may not be aligned. We are interested to hear whether you think we have got this right, or whether there are important issues we have missed. We will be asking you questions to guide the discussion (you will find these gathered together at the end of the document), but you can tell us about any other ideas or concerns you have as well.

How to have your say

Please take the time to make a submission. Full instructions for making a submission can be found in the submission form provided. The submission form also lists the consultation questions found throughout the discussion document to help submitters complete the submission process.

Your feedback is very important: it will help shape the advice and recommendations to the Ministerial Committee on Disability Issues on what people said and options for addressing significant issues and concerns.

All submissions are due with the Ministry by 5pm on Friday, 24 February 2017 .
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Navigating this document

Part One provides an overview of the Mental Health Act, the CRPD and NZBORA, and looks at whether they are consistent.

Part Two sets out in more detail the key issues and concerns that have been highlighted in commentary about the Mental Health Act – in the literature and by the reference group – regarding the impacts of the Mental Health Act from a human rights perspective.

At the beginning of each main section we have included a summary of key points and the issues we would like your feedback on. We hope this makes it easier to navigate the document.

Part One: Overview of the Mental Health Act, CRPD and NZBORA

Part One provides an overview of the Mental Health Act, the CRPD and NZBORA, and the extent to which they are consistent. The rights and protection of people who come under the Mental Health Act are also covered in other legislation and treaties. Appendix 1 provides a summary of other relevant legislation/treaties, including Te Tiriti o Waitangi (the Treaty of Waitangi).

Key points

Mental Health Act

- The Mental Health Act sets out the circumstances in which people may be subject to compulsory (psychiatric) assessment and treatment. To be admitted under the Act, a person must be assessed as meeting the two-step definition of ‘mental disorder’. The Act defines the rights of such people and provides protections for those rights.

Convention on the Rights of People with Disabilities (CRPD)

- The CRPD was ratified by New Zealand in 2008. Its purpose is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities (including people with mental illness), and to promote respect for their inherent dignity.
- Articles 3(a), 12, 14, 17 and 25 of the CRPD (see Appendix 2) are particularly relevant to tangata whaiora / service users and discussions about the relationship between the CRPD and Mental Health Act. Article 12 is a central article and requires equal recognition before the law for people with disabilities, including the right to exercise legal capacity (with support if necessary). Interpretation of Article 12 is not yet settled.

Committee on the Rights of People with Disabilities

- The United Nations Committee on the Rights of Persons with Disabilities considers the current Mental Health Act to be inconsistent with the CRPD on the basis that *involuntary* detention of those with mental illness is considered to be discriminatory.

New Zealand Bill of Rights Act 1990 (NZBORA)

- NZBORA sets out a number of rights dealing with all aspects of government, including the right to be free from discrimination on the grounds of, among other things, psychiatric illness and psychological disability (section 19[1]). The Mental Health Act must be interpreted by those who implement it to best affirm, protect and promote the rights contained in NZBORA.
- However, the rights set out in NZBORA are not absolute. NZBORA says those rights can be limited if the restrictions are reasonable, lawful and can be ‘demonstrably justified in a free and democratic society’ (section 5). The question to be asked in each case is ‘would a certain limit on rights be proportionate in the circumstances? If so, it may be justified’ (Dawson 2015).

We would like your feedback on these issues:

1. How well do you think the Mental Health Act does in promoting and protecting human rights?
2. What changes do you think are needed in order to make the Mental Health Act and its administration more aligned with our obligations under NZBORA and the CRPD?

Mental Health Act

The Mental Health Act sets out the circumstances in which people may be subject to compulsory (psychiatric) assessment and treatment. The Act also defines the rights of such people and provides protection for those rights. The Mental Health Act aims to provide treatment for ‘mentally disordered’ patients or those being assessed as potential patients in a way that favours community treatment while still providing treatment to those who require hospital-level (inpatient) treatment. Another key purpose of the Act is to make sure that assessment and treatment occur in the least restrictive manner possible, consistent with safety.

The definition of ‘mental disorder’ in the Mental Health Act (section 2) governs entry into and exit from compulsory assessment and treatment for mental disorder. The definition of ‘mental disorder’ has two parts to it. First, a person must be assessed as having an ‘abnormal state of mind (whether of a continuous or intermittent (occasional) nature), characterised by delusions, or by disorders of mood or perception or volition (ability to make choices) or cognition (understanding)’. Second, the ‘abnormal state of mind’ must be ‘of such a degree that it –

- poses a serious danger to the health or safety of self or others; or
- seriously diminishes the capacity of that person to take care of himself or herself.’

A person may be certified by a doctor for compulsory assessment when there are ‘reasonable grounds to believe’ they are ‘mentally disordered’; a judge may make a compulsory treatment order for a person who is ‘mentally disordered’; and a person may remain under compulsory treatment for as long as they meet this test. If they cease to meet it, they are entitled to be released.

The Mental Health Act applies only to those people with mental disorder who satisfy the two-step process above. The first step requires the presence of an ‘abnormal’ state of mind, either continuously or intermittently, and the second requires that the presence of that state of mind causes consequences of a certain severity. No one can be subject to an assessment or treatment order based on having an ‘abnormal state of mind’ alone.

A person cannot be subject to the Mental Health Act solely as a result of intellectual disability, substance abuse, personal, political or religious beliefs, or criminal or delinquent behaviour (section 4). However, people who are under the Mental Health Act may have an intellectual disability, may have acquired brain injury or may have substance abuse problems, but they must also meet the two part definition of mental disorder above.

In 2015 around 162,200 New Zealanders were engaged with specialist mental health services, and of these around 6.1 percent were being treated under the Mental Health Act (Ministry of Health 2016).

In addition to the right to review (sections 16 and 79), the Mental Health Act includes the following patient rights, which apply as soon as the person becomes a patient under the Act (sections 63A to 75):

- information about their legal status
- respect for cultural identity
- access to an interpreter
- treatment
- be informed about treatment
- refuse video recording
- independent psychiatric advice
- legal advice
- company
- have visitors and make telephone calls
- send and receive mail
- complain about a breach of rights.

The rights in sections 63A to 75 of the Mental Health Act supplement the rights affirmed in NZBORA and the rights enjoyed by all health service consumers under the Health and Disability Services Consumer Code of Rights 1994.

The Mental Health Act should be read alongside the Ministry of Health's guidelines on the Mental Health Act (Ministry of Health 2012a) and other guidance specifically directed at statutory officials. The guidelines are intended to support the effective and lawful use of the Mental Health Act. They are also intended to help people who are concerned about the operation of the Act (including tangata whaiora / service users and their families and whānau) to understand how it is intended to operate.

Convention on the Rights of Persons with Disabilities

Overview

In December 2006 the United Nations General Assembly adopted by consensus the Convention on the Rights of Persons with Disabilities (CRPD). New Zealand ratified the CRPD on 25 September 2008, and in doing so became a 'State Party' to the CRPD.

In New Zealand, international conventions such as the CRPD do not automatically become part of New Zealand law and are not directly enforceable through the courts, as they are in some other countries. However, by ratifying the CRPD New Zealand does have an obligation to implement it and, like any other international convention to which New Zealand is party, it can be referred to by courts and can be used to interpret domestic law.

The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity (Article 1). The CRPD obligates State Parties to prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds (Article 5).

The CRPD clarifies the application of human rights to people with disabilities. It does not introduce new rights. The preamble recognises that ‘disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’. The CRPD emphasises the importance of individual rights in the balance between respect for individual autonomy and harm to others (McSherry and Wilson 2011).

The UN Committee on the Rights of Persons with Disabilities (ComRPD) is the expert body established by the United Nations to interpret the language in the CRPD. Since 2006, understanding of what constitutes discrimination has been shifting, particularly as further commentary has been issued by the ComRPD and other UN committees.

On 5 October 2016, New Zealand agreed to the Optional Protocol to the CRPD. This means that disabled people will be able to submit a complaint to the United Nations Committee on the Rights of Persons with Disabilities if they consider their rights under the Convention have been breached. Complaints can only be made after that date, and all domestic remedies or complaints processes must have been completed first.

Defining disability

The CRPD does not define ‘disability’ or ‘persons with disability’, but Article 1 states that ‘persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments that, in the face of various negative attitudes or physical obstacles, may prevent those persons from participating fully in society’. While the CRPD refers to long term impairments, the non-exclusive use of the word “includes” provides flexibility in this interpretation. The intention that the CRPD should apply to all mental illness governed by domestic legislation seems clear from the ComRPD’s comments and guidance (ComRPD 2014).

Rights of tangata whaiora / service users

The four rights in the CRPD of particular relevance to tangata whaiora / service users and discussions about the relationship between the CRPD and Mental Health Act are:

- the right to equal recognition before the law (Article 12)
- the right to liberty and security of the person (Article 14)
- the right to respect for physical and mental integrity on an equal basis with others (Article 17)
- the right to the highest attainable standard of health without discrimination on the basis of disability (Article 25).

The principles contained in Article 3 are also important, particularly principle 3(a).

Articles 12, 14, 17 and 25 are set out in full in Appendix 2.

Compulsory detention and treatment

Compulsory detention and treatment can affect the most fundamental rights, such as a person's right to equality before the law and the right to liberty. For this reason, international human rights standards have set out strict safeguards to limit undue interference in these rights. The CRPD strongly confirms these safeguards while calling for people with disabilities, including mental illness, to be treated on an equal basis with others. The ComRPD released its general comment on Article 12 in 2014 and guidance on Article 14 in 2015.

Article 12

Article 12 of the CRPD affirms that people with disabilities have the right to be treated equally before the law, and it underpins many of the other rights and obligations in the CRPD. Article 12 includes the right to:

1. enjoy legal capacity on an equal basis with others in all aspects of life
2. access to the support required to exercise their legal capacity
3. appropriate and effective safeguards to prevent abuse in accordance with international human rights law
4. safeguards that ensure measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible, are subject to regular review by a competent, independent and impartial authority or judicial body, and are proportional to the degree to which such measures affect the person's rights and interests.

While interpretation of the CRPD is not yet settled (Callaghan and Ryan 2014), the ComRPD has made it clear in their interpretation that the CRPD requires a shift from substituted decision-making (decision-making transferred to others) to supported decision-making (a person is supported to make the decision) (ComRPD 2014).

However, a number of commentators on mental health law express the view that Article 12(4) does allow some scope for acknowledging the reality of substituted decisions and involuntary treatment where people have been found to lack the mental competence to make a decision. This is provided it prioritises respect for a person's 'will and preferences' and ensures respect for all their human rights, interpreted in a way that is least restrictive of those rights. They argue that the ComRPD fails to recognise the difficulties that can be involved in determining a person's genuine 'will and preferences' when their mental function is severely impaired and they have left no clear expression of their wishes (Callaghan and Ryan 2014; Szmukler et al 2014; Dawson 2015; Stavert 2015).

Few, if any, jurisdictions' mental health laws fully comply with the ComRPD's interpretation of the CRPD (Stavert 2015). However, the CRPD has had an impact on the development of new mental health legislation in a number of Australian states and other international jurisdictions through greater recognition of human rights obligations in mental health law.

While there is likely to be ongoing debate on the meaning of Article 12 in terms of any legislative change, it does provide an opportunity to look at whether improvements can be made in the mental health system to give greater respect to the will, preferences and human rights of tangata whaiora / service users.

Article 14

Article 14 of the CRPD affirms the right to liberty and security of the person and clearly states that the deprivation of liberty based on the existence of a disability would be contrary to the CRPD. Under Article 14(2), people with disabilities deprived of their liberty through any process 'are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and to be treated in compliance with the objectives and principles of the CRPD, including provision of reasonable accommodation' (ComRPD 2015, page 2).

Regarding Article 14, the ComRPD states, among other things, that

the legislation of several States parties, including mental health laws, still provide instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. This practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty (ComRPD 2015, page 5).

New Zealand Bill of Rights Act 1990

The New Zealand Bill of Rights Act (NZBORA) was enacted in 1990 and sets out a number of rights for people when they are dealing with all areas of the government: employees, all departments, courts, state-owned enterprises and local authorities. NZBORA does not make other laws ineffective (section 4). However, the provisions (including those that authorise compulsory treatment) must be interpreted, as far as possible, consistently with NZBORA (section 6).

A number of NZBORA rights issues are relevant to the operation of the Mental Health Act, including:

- section 9 of NZBORA, which provides that everyone has the right not to be subject to torture, or to cruel, degrading or disproportionately severe treatment or punishment
- section 11, which states that everyone has the right to refuse to undergo any medical treatment
- section 23, which includes the right for everyone deprived of liberty (under any enactment) to be treated with humanity and with respect for the inherent dignity of the person.

NZBORA (section 19[1]) provides that everyone has the right to freedom from discrimination on the grounds set out in the Human Rights Act 1993 (see Appendix 1). The grounds in the Human Rights Act include 'disability', which is defined to include, among other things, psychiatric illness; intellectual or psychological disability or impairment; or any other loss or abnormality of psychological, physiological, or anatomical structure or function. This wide definition of disability

indisputably covers those who satisfy the first step of having an ‘abnormal state of mind’.

The definition of ‘mental disorder’ in the Mental Health Act must be interpreted by the courts and Mental Health Review Tribunal (the Review Tribunal) and by the responsible clinician in accordance with NZBORA to best affirm, protect and promote the rights contained in NZBORA. Any of several affirmed rights in NZBORA might be infringed in using the Mental Health Act, depending on the nature of the compulsory treatment order made, but in almost every case the right to refuse medical treatment (section 11 of NZBORA) will be limited (McKillop 2012).

However, the rights set out in NZBORA are not absolute. They are subject ‘only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society’ (section 5). There are exceptional circumstances where it is necessary for a person’s rights to be restricted to protect themselves or the rights of others. Such measures represent an exceptional expansion of the normal powers of the state. The question to be asked in each case is ‘would a certain limit on rights be proportionate in the circumstances? If so, it may be justified’ (Dawson 2015). Or, to put it another way, could any less drastic means have achieved the aims?

Consistency between the Mental Health Act, CRPD and NZBORA

This section focuses on whether the current test of ‘mental disorder’ under the Mental Health Act is consistent with the CRPD and NZBORA.

Mental Health Act and the CRPD

In October 2014 the ComRPD reported and recommended that New Zealand ‘take all the immediate necessary legislative, administrative and judicial measures to ensure that no one is detained against their will in any medical facility on the basis of actual or perceived disability’. The ComRPD also recommended that New Zealand ‘ensure that all mental health services be provided on the basis of the free and informed consent of the person concerned, in accordance with the [CRPD]’ and that ‘[the MHA] be amended to comply with the [CRPD]’. The Mental Health Act does not recognise the concept of legal capacity at all and is therefore unlikely to be consistent with Article 12¹ (ComRPD 2014a, page 4).

While the recommendations are not legally binding on New Zealand, as noted above, the various statements made by the ComRPD are clear in their view that it is not acceptable to discriminate on the basis of mental disorder. They also state that the second part of the ‘mental disorder’ test in the Mental Health Act (ie, risk to self or others or seriously diminished capacity to care for oneself) does not remove the discriminatory nature of the overall test.

¹ Note: the Mental Health Act only provides for compulsory treatment for mental disorder. It does not address treatment, consent or capacity for any other condition.

Mental Health Act and NZBORA

Decisions by the court and comments made about the Mental Health Act by the Attorney-General suggest the current test of 'mental disorder' in the Act is compliant with NZBORA. These comments tend to rest on the second part of the mental disorder test. However, if in the future the courts were to find that the 'mental disorder' test is discriminatory, it would then be necessary for them to assess whether that discrimination can be demonstrably justified (under section 5 of NZBORA).

Part Two: Mental Health Act – the issues

The following sections set out some of the key issues and concerns that have been highlighted in the literature, in commentary, and by the Reference Group regarding the impacts of the Mental Health Act from a human rights perspective, with reference to the relevant articles/provisions in the CRPD and NZBORA. We are also interested in your experiences and understanding of the Mental Health Act.

Individual autonomy and informed consent

Compulsory detention and treatment of seriously mentally ill people raises complex ethical and human rights issues relating to individual autonomy, and informed consent and efficacy relating to community treatment orders.

(CRPD Articles 12, 14, 17 and 25 and NZBORA section 11 are particularly relevant).

Key points

- ‘Consent’, as used in the Mental Health Act, is not the same as ‘informed consent’ in that it entails some degree of coercion.
- This raises ethical issues and is inconsistent with the rights that apply to general medical care in New Zealand, including the right to refuse medical treatment, even though a significant proportion of mentally ill people are likely to be competent to give informed consent.
- Our Reference Group said that tangata whaiora / service users and family and whānau need time with clinicians to discuss and fully understand all treatment options, and not just medication. This includes time to discuss advance directives.

We would like your feedback on these issues:

3. Do you think the views and preferences of tangata whaiora / service users are taken into account sufficiently in decisions about their treatment? What is your experience?
4. What is your experience of consultation with the families and whānau of both adults and young people subject to the Mental Health Act, including in relation to treatment options? Is it culturally appropriate? How could it be improved?

The Mental Health Act and consent

Section 59 of the Mental Health Act obliges a patient to accept treatment during the first month of a compulsory treatment order. If during that first one-month period the responsible clinician is satisfied the patient will need further treatment beyond that period and that the patient is unlikely to consent, the clinician may refer the case to a second-opinion psychiatrist (appointed for this purpose by the Review Tribunal) so that further treatment is available at the end of the month.

After that first one-month period the patient is not required to accept any treatment unless, having had the treatment explained to them, they consent in writing to the treatment *or* the treatment is considered to be in the interests of the patient by a psychiatrist providing a second opinion.

The Ministry's guidelines on the Mental Health Act set out the factors a psychiatrist should consider in providing a second opinion. The opinion should be limited to the psychiatrist's views as to whether the treatment is in the 'interests' of the patient and not whether the person should remain under the Act. It should also be the least restrictive alternative, and proportionate to the assessed risks (Ministry of Health 2012a).

Under section 60 of the Mental Health Act no patient is required to accept electroconvulsive therapy (ECT) for 'mental disorder' unless they consent in writing or the treatment is considered to be in the interests of the patient by a psychiatrist (not the responsible clinician) who has been appointed by the Review Tribunal for this purpose.

The Mental Health Act (section 59[4]) states that the responsible clinician shall, wherever practicable, seek to obtain the consent of the patient to any treatment even though that treatment may be authorised by or under the Act without the patient's consent.

'Consent', as it is used in section 59(2)(a) of the Act, is not the same concept as 'informed consent', which should be obtained in the absence of coercion: consent to compulsory treatment necessarily entails some degree of coercion having been used already. In this case the patient whose consent is sought is already subject to a compulsory treatment order, and a refusal of consent will not necessarily bring a compulsory treatment order to an end. (Ministry of Health 2012a).

The Ministry of Health's guidelines on the Mental Health Act (page 56) state that consent should only be sought when the person has the mental competence to make that decision. The guidelines state that a patient will not have the mental competence to consent if they are unable to:

- understand the information
- retain that information
- use or weigh that information as part of making a decision, or
- communicate that decision (by any means).

Right to autonomy and informed consent

Individual autonomy and informed consent to treatment are central principles in medical ethics and are emphasised in the CRPD, NZBORA and the Health and Disability Commissioner Act and Code of Rights. Decisions should only be made by a person once they have received all the necessary information, including the perceived medical condition they are facing, the treatment options, the treatment plan and possible side-effects. People are generally assumed to be competent to consent unless there are reasonable grounds for believing they lack competency (Right 7[2] of the Code of Rights).

The Mental Health Act (sections 59 and 60) places a significant limitation on the right to autonomy and informed consent to treatment because it allows the treatment

choices of ‘mentally disordered’ patients with mental competence to consent to be over-ridden. This is inconsistent with the rights that apply to general medical care in New Zealand and under the CRPD.

Two conceptually distinct areas of autonomy may be compromised in the treatment of mentally ill persons:

- the loss of liberty associated with hospital or detention, which may be seen as necessary to protect the health interests of the patient or others
- the compromise to autonomy resulting from compulsory treatment (Skipworth 2013).

Evidence suggests that a significant proportion of ‘mentally disordered’ people retain the mental competence to consent (Skipworth 2013). Separating the two issues above – though appealing as a way of limiting the state’s use of exceptional powers – opens the way for the ethically fraught situation of detaining people without treatment because they pose a risk to themselves or others, if treatment can be competently rejected by a detained patient (Skipworth 2013).

While this group is likely to be small, it would be important to think through the potential impacts of detaining without treatment on the individuals concerned, and on families/whānau and services.

Right to be informed about treatment options

People with mental illness are entitled to information about treatment options before starting treatment, including the expected benefits and likely side-effects of any treatment (section 67 of the Mental Health Act). This right supplements the general right of all health service consumers to receive all the information about treatment options and risks that any reasonable person, in the same circumstances, would expect to receive (rights 6[1] and 6[2] of the Code of Rights).

Our Reference Group said that tangata whaiora / service users and families/whānau need time with members of the treatment team to fully understand all possible treatment options (not just medication) and the potential side-effects. This includes the time to discuss advance directives to be used at those times when a person is too acutely ill to consent to treatment. They also said that medication, while potentially helpful for addressing the symptoms of mental illness, does not address trauma. However, treatment options other than medication are not always offered or discussed.

Right to refuse medical treatment

Significant ethical issues are raised by the power to take away a person’s right to refuse treatment when they come under the Mental Health Act. This is particularly so where there are known harmful side-effects, or the long-term effects are unknown, and a person is competent to make decisions about treatment and wishes to avoid the side-effects (eg, an increased risk of diabetes, metabolic and cardiovascular disease associated with the use of psychotropic medication) (Te Pou o te Whakaaro Nui 2016).

Members of the Reference Group expressed concern that people under the Mental Health Act face greater restrictions on their autonomy than people in other parts of

the health system, without a clear rationale. Under the Mental Health Act we significantly limit the right to refuse treatment for mental disorder from competent people with severe mental illness (where they meet the second test of the definition of ‘mental disorder’) but we allow this choice for those with severe physical illness such as cancer or diabetes (an individual can refuse chemotherapy or insulin), even though this carries a serious risk to the person and in some circumstances to others. This is in spite of the fact that the incidence of serious harm to others by seriously mentally ill people is very low (Mental Health Research Project 2003; Mellsop et al 2015).

Advocacy and support

(CRPD Article 12 is particularly relevant.)

<p>Key points</p> <ul style="list-style-type: none">• The CRPD requires that people be supported to exercise their legal capacity.• The Office of Disability Issues is undertaking work to develop a shared understanding of supported decision-making in the New Zealand context.• Peer support/advocacy, advance directives, family/whānau consultation, and care prevention plans provide opportunities for tangata whaiora / service user and family/whānau involvement in decision-making under the Mental Health Act.
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<p>We would like your feedback on these issues:</p> <p>5. How might tangata whaiora / service user decisions be better supported?</p> <ul style="list-style-type: none">a. What supports are needed by seriously ill mental health patients to make decisions?b. What about those persons with mental illness who do not have support networks?c. What is the role of peer support, independent advocates and advance directives in supporting decision-making?
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Article 12(3) of the CRPD specifically refers to supports as follows: ‘States parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.’ Supported decision-making is not specifically defined in the CRPD, but the ComRPD describes supported decision-making in its 2007 publication, *Handbook for Parliamentarians*:

Supported decision-making can take many forms. Those assisting a person may communicate the individual’s intentions to others or help him/her understand the choices at hand. They may help others to realize that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity ... The individual is the decision maker; the support person(s) explain(s) the issues, when necessary, and interpret(s) the signs and preferences of the individual. Even when an individual with a disability requires total support, the support person(s) should

enable the individual to exercise his/her legal capacity to the greatest extent possible, according to the wishes of the individual.

The Office of Disability Issues is undertaking work over the next year to help develop a shared understanding of what the CRPD's concept of 'supported decision-making' might involve in the New Zealand context. This is part of a broader programme of work under the Disability Action Plan aimed at achieving greater consistency with the CRPD.

In the meantime, the Ministry's Reference Group has highlighted a number of issues for tangata whaiora / service users and families/whānau relating to the level of involvement in decisions about treatment for mental disorder under the Mental Health Act, and where improvements could be made. These are set out below.

Independent advocacy and peer support

Access to independent advocacy and peer support is an important mechanism through which individuals with mental disorder, whether subject to the Mental Health Act or not, can be supported to navigate the system and make decisions or express their needs and views to those who are making decisions about their treatment.

Tangata whaiora / service users have access to advocacy through the Health and Disability Commissioner Advocacy Service. DHB-funded consumer advisors also advocate on behalf of consumers under the Mental Health Act. Peer support is provided by a range of non-government organisations, although access to peer support varies across the country. However, the Reference Group told us that many tangata whaiora / service users and family/whānau often feel unsupported through the processes under the Mental Health Act.

Advance directives

Advance directives (or living wills) can play an important role in recognising choice and allowing individuals to be self-determining. Right 7(5) of the Health and Disability Commission Code of Rights states that 'Every consumer may use an advance directive in accordance with the common law'. The Ministry of Health's guidelines on the Mental Health Act state that clinicians should take steps to give effect to prior, competently expressed wishes when reasonably practicable and clinically indicated. We understand that advance directives are not widely used in mental health services in New Zealand at present.

The Health and Disability Commissioner advises that the validity of an advance directive will revolve around four key issues:

1. whether the consumer was competent to make the particular decision, when the decision was made; and
2. whether the consumer made the decision free from undue influence; and
3. whether the consumer was sufficiently informed to make the decision; and
4. whether the consumer intended his or her directive or choice to apply to the present circumstances.

A person can also choose to nominate other people to make decisions regarding their personal welfare or property rights, in part or wholly, for a time when, at some point in the future, the person loses their mental competence to make decisions or communicate them (also known as enduring powers of attorney).

Family/whānau consultation

The Mental Health Act emphasises the importance of consulting with families and whānau during the compulsory assessment and treatment process unless it is not in the best interests of the patient or proposed patient (based on a discussion with them), or it is not reasonably practicable (section 7A of the Mental Health Act). Consultation is expected to be an ongoing process. The requirement to consult does not mean a patient or proposed patient loses their right to confidential care and treatment.

In 2015, 59 percent of all Mental Health Act assessment/treatment events involved consultation with family or whānau. Families/whānau were most likely to be consulted during a person's initial assessment (section 10) under the Mental Health Act. The most common reason families/whānau were not consulted during assessment or treatment was that it was deemed not reasonably practicable in the given circumstance (Ministry of Health 2016).

Further exploration of what 'not reasonably practicable' means is needed. The Ministry does not currently require district health boards to provide this level of detail in their reporting.

Care/prevention plans

The Reference Group highlighted the importance of meaningful care or relapse prevention plans, with tangata whaiora / service users placed at the centre of the plan. Ideally, the plan would be developed by the person him/herself, with support from their clinician and their whānau or family.

Checks and balances in the system

(CRPD Article 1 – Purpose, Article 14 and NZBORA section 23 are particularly relevant.)

Key points

- The Mental Health Act has a number of checks and balances to safeguard against inappropriate use of the coercive powers under the Act.
- Tangata whaiora / service users and families/whānau do not always understand their rights and protections under the Mental Health Act.
- There is scope to improve the implementation of checks and balances under the Mental Health Act. The following have been suggested as potential areas:
 - promote a better understanding of the role of the district inspector
 - improve the Review Tribunal environment to make it a more positive and engaging experience for tangata whaiora / service users, and for family and whānau
 - increase transparency and consistency around the second-opinion psychiatrist process
 - ensure people under the Mental Health Act are appropriately supported to challenge their compulsory status, if they wish to.

We would like your feedback on this issue:

6. Does the current system of protections under the Mental Health Act adequately meet the needs of people under the Act? Where are the gaps and where do you think improvements could be made, including for:
 - a. Māori tangata whaiora /service users?
 - b. Pasifika tangata whaiora / service users?
 - c. people from other cultural/ethnic backgrounds?
 - d. young people?
 - e. people with learning disabilities and cognitive impairments (including older people with dementia)?

The Mental Health Act includes a number of checks and balances to provide safeguards against inappropriate use of the coercive powers under the Act. The subsections below set out the key checks and balances, and some of the concerns around their implementation.

Duly authorised officer

Duly authorised officers are appointed by the Directors of Mental Health Services under section 93 of the Mental Health Act. The duly authorised officer is a health professional and has a key role in informing and educating proposed patients, current patients, and their whānau and families, particularly in the process of seeking an assessment under the Mental Health Act.

District inspectors

District inspectors are lawyers appointed under the Mental Health Act. Their role is to assist people who are being assessed or treated under the Act by providing information and support to ensure the patient's rights under Part 6 of the Act are being upheld. This is an important safeguard of the rights of patients being treated under the Act.

However, we have been told that the role of the district inspector is generally not well understood by clinicians, tangata whaiora/service users, and families and whānau, and that this may prevent people from approaching district inspectors for assistance. There is also a view that district inspectors have a limited mandate to require change if they think it is needed.

In a study on how district inspectors work in practice, based on material generated from 20 semi-structured interviews with district inspectors during 2011, a number of challenges for the role were identified:

Clinical staff's misunderstandings about the nature of the [district inspector] role made it difficult for them to present themselves as detached from clinical decision-making and not a patient advocate. At times patients, their families and clinical staff lacked necessary information and some [district inspectors] felt that this led to complaints going unheard. This was particularly relevant in the community, where patients were not visited as frequently by [district inspectors], even though the Mental Health Act prioritises the community as the site for compulsory assessment and treatment. (Thom and Prebble 2013)

The study suggests that more education is needed on the district inspector role.

Mental Health Review Tribunal

The Mental Health Review Tribunal is an independent body appointed by the Minister of Health under the Mental Health Act. It decides, among other things, whether patients are fit to be released from compulsory status, investigates complaints about breaches of patient rights, and appoints second-opinion psychiatrists and psychiatrists, who decide whether ECT is in the best interests of patients.

The Review Tribunal has been likened by some tangata whaiora/service users and family/whānau to a court hearing. This can create a sense of 'us and them' at Tribunal hearings rather than an environment conducive to discussion about a person's treatment needs and recovery goals.

Concern has also been expressed about the imbalance, in terms of influence, of members on the Review Tribunal, with the legal and clinical members on the Review Tribunal seen as having more influence than the community member.

Second opinions

In 2013 an audit of documentation relating to the way second-opinion psychiatrists carried out treatment approval process under sections 59 and 60 of the Mental Health Act was undertaken (Dawson et al 2013). The audit found considerable

variability across centres in how second-opinion processes are implemented and recorded, including:

- marked differences in how second-opinion psychiatrists were designated to review the treatment of individual patients
- the number of clinicians who performed the second-opinion role
- their degree of independence from treating clinicians
- the forms they completed and the steps they took in the approval process.

The review recommended the development of clear processes to assess and document the second-opinion process nationally, and for all involved to implement effective quality assurance procedures. These steps are seen as important to maximise the probability that patients receive high-quality second-opinion psychiatrist reviews of their treatment in all centres across New Zealand (Dawson et al 2013).²

Court/legal processes

There is a sense that the legal system should be more supportive of tangata whaiora / service users who come under the Mental Health Act. Concerns have been raised about:

- the general quality of legal representation, in terms of a lack of understanding about mental health issues and the Mental Health Act
- a perceived disproportionate emphasis on clinical advice in court decisions (compounded by a sense that the clinical advice provided by a second-opinion psychiatrist is seen as often aligning more with the first clinical assessment rather than being truly independent).

This is a particular concern for those who are subject to long-term compulsory treatment orders.

Reviews of compulsory treatment

A person under the Mental Health Act can apply to have their compulsory treatment status reviewed by the Mental Health Review Tribunal. The Review Tribunal can also initiate a review or refuse to review a patient's case (sections 35[2] and 79).

In addition, if a person or other complainant is not satisfied with the outcome of a complaint of a breach of rights made to a district inspector, he or she may refer the case to the Review Tribunal for further investigation.

In the year ended 30 June 2015 the Review Tribunal received 145 applications to review civil (not forensic) compulsory treatment orders (under section 79 of the Mental Health Act). Of those, 58 were reviewed during the year and five people (8 percent) were considered fit to be released from compulsory status (slightly higher than the average over the previous 10 years (6 percent)).

To be discharged from compulsory status, a person must meet the legal standard of being 'fit to be released from compulsory status' (refer to sections 34[2], 35[2], 76[5] and 79[8] of the Mental Health Act). In the *Waitemata Health v A-G [2001] NZFLR 1122* case (the leading authority on the interpretation of 'fit to be released from

² Note that, as the study was based solely on records kept, it did not comment directly on the actual quality of the review of treatment conducted.

compulsory status’), the Court of Appeal held that the phrase means that a patient is no longer mentally disordered and *thereby* fit to be released. The ‘exit’ criterion of being fit to be released (no longer mentally disordered) is not the same as the ‘entrance’ criteria (mentally disordered *and* necessary to undergo compulsory assessment and treatment). The Court’s consideration of ‘whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory treatment order’ is an additional protection for a person being considered for compulsory treatment that is not available to people who are seeking to be released from the Mental Health Act.

There is concern that processes under the Act do not adequately support people to challenge their compulsory status, and that this might be contributing to the low rate of decisions to release someone from compulsory status. Following its country visit to New Zealand in early 2014, the United Nations Working Group on Arbitrary Detention expressed concern that, in practice, compulsory treatment orders are largely clinical decisions and difficult to challenge effectively.

Respect for cultural identity and personal beliefs

(Respect for cultural identity and personal beliefs is an ethical imperative and is captured under the general purpose and principles of the CRPD, NZBORA, the Treaty of Waitangi and the United Nations Convention on the Rights of Indigenous People.)

Key points

- The Mental Health Act requires that the powers under the Act be exercised with respect for a person’s culture, language and beliefs (sections 5 and 6), as does the Health and Disability Services Consumers’ Code of Rights (Right 1[3]).
- Māori and Pacific people are disproportionately represented in populations subject to the Mental Health Act. Both populations also present late to non-compulsory mental health services.
- At a 2015 hui of Māori tangata whaiora, participants described their often negative experiences of coercion under the Mental Health Act. They also highlighted their need for holistic services, incorporating tikanga Māori (Māori customs), te reo Māori (Māori language), mātauranga Māori (Māori concepts) and increased whānau involvement in their care and treatment.
- For Pacific tangata whaiora / service users and families, fear of coming under the Mental Health Act may be contributing to mistrust of mental health services generally, and many struggle to understand the processes under the Act.

We would like your feedback on these issues:

7. What is your experience of cultural competency in the services provided under the Mental Health Act? When should cultural assessment be used?
8. What do you think constitutes ‘proper recognition’ of whānau, hapū and iwi in terms of use of the Mental Health Act? (This is set out in the Mental Health Act guidelines: it is not defined, but it is described).
9. What changes would you like to see?

The Mental Health Act (sections 5 and 6) requires powers under the Act to be exercised with respect for a person's culture, language and beliefs. Section 5(2)(a) requires 'proper recognition of the importance and significance of the person's ties with his or her family, whānau, hapū, iwi and family group.' Section 65 of the Mental Health Act affirms that 'every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5'.

The guidelines on the Mental Health Act (Ministry of Health 2012a) provide some guidance on what 'proper recognition' means. The guidelines focus on encouraging the relationship between the tangata whaiora / service user and their family/whānau where it is beneficial to the person's wellbeing, and early and ongoing engagement with family/whānau throughout treatment.

The Code of Rights provides in Right 1(3) that 'Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values and beliefs of Maori.' The importance of cultural assessment to cultural safety and treatment outcomes is highlighted in the literature. Cultural assessment acknowledges the link between identity, wellness, treatment and recovery, and is important whatever the culture (Mental Health Commission 2004).

Strengthening kaupapa Māori approaches

Māori are over-represented in populations treated under the Mental Health Act. In 2015, as a population group Māori were:

- 3.6 times³ more likely to be subject to a community treatment order (section 29) than non-Māori (330 per 100,000 compared with 91 per 100,000), up from 3.5 in 2014
- 3.3 times more likely to be subject to an inpatient treatment order (section 30) than non-Māori (114 per 100,000, compared with 35.5 per 100,000)
- secluded almost five times more than non-Māori (89 per 100,000 compared with 18 per 100,000) (Ministry of Health 2016).

It is likely that a number of factors contribute to this over-representation, including significant disparities between Māori and non-Māori in rates of serious mental illness, co-existing conditions, and complex and late presentation to services (Elder and Tapsell 2013). The youthfulness of the population and socioeconomic disparities between Māori and non-Māori population groups are also relevant factors in considering Māori mental health need.

Elder and Tapsell note that 'overall, the potential for bias in the assessment of "mental disorder" leaves open to question whether the disproportionate use of the Mental Health Act for Māori signifies an appropriate response to high and complex needs, or constitutes a pathologising⁴ of Māori presentations, or a mixture of both'.

³ This ratio is based on the age-standardised rates of the Māori and non-Māori populations. The same applies for the section 30 ratio that follows.

⁴ Pathologising is the practice of seeing a symptom as indication of a disease or disorder. In mental health, the term is often used to indicate over-diagnosis or the refusal to accept certain behaviour as normal.

More research, particularly using rangahau kaupapa Māori methods, is needed to better understand why so many Māori are treated under the Mental Health Act, and the nature of their experience (Elder and Tapsell 2013).

Elder and Tapsell go on to state that ‘reduced bias is likely with improved cultural competency in the mental health workforce, focused on cultural formulations meaningful for whānau, leading to improved decision-making’. They argue that ‘alongside this, senior cultural workers fluent in Te Reo Māori and proficient in tikanga are an essential part of ensuring the validity of the formulation and of providing culturally informed processes of assessment and management’ (Elder and Tapsell 2013). This has been reinforced by other studies and hui (Te Pou o te Whakaaro Nui 2014; Baker 2015).

At a 2015 hui to discuss Māori tangata whaiora experience of being under the Mental Health Act, participants described their experience of acute mental health services as ‘restrictive’ and ‘disempowering’, and their sense that the treatment they received was more closely aligned with the clinicians’ needs than their own. They also described experiencing overt discrimination in the community, such as disproportionately harsh treatment by police and refusal of accommodation and employment due to the stigma that continues to surround community treatment orders (Baker 2015).

Those at the hui emphasised their need for a holistic approach to assessment and service provision, incorporating tikanga Māori (Māori customs), te reo Māori (Māori language), mātauranga Māori (Māori concepts) and increased whānau involvement in their care and treatment (Baker 2015). Māori consumer advocates have said that for those tangata whaiora who are disconnected from their whānau, it is important to involve Māori non-government organisations and advocates in the process. Their role in facilitating cross-cultural exchange between the person and the clinical team is particularly important in moments of crisis, when things can escalate badly.

There are no doubt opportunities to use cultural assessment (competently undertaken) to a greater extent, both before and after a person comes under the Mental Health Act. For example, it has been suggested that cultural assessments/recommendations should be provided alongside clinical assessments in the Courts and the Review Tribunal when reviewing a person’s condition and making recommendations about ongoing treatment (eg, whether they should remain under the Mental Health Act).

The importance of providing a culturally safe, respectful setting for treatment and recovery has been highlighted as a critical component of recovery for Māori tangata whaiora. A small study of Māori mental health nurses who have worked in acute mental health inpatient units in New Zealand found that there are factors that have a negative impact on the interaction between Māori and acute mental health services, such as the environmental context of the unit, the variable pathway of care in mental health services and the use of medication and seclusion (Te Pou o te Whakaaro Nui 2014).

Improving responsiveness to Pacific people

Pacific people use the Mental Health Act at a disproportionately high rate. In 2015 Pacific people were twice as likely as non-Māori to be subject to a community

treatment order (195 per 100,000 population compared with 97 per 100,000 for non-Māori). Pacific people were also twice as likely as non-Māori to be subject to compulsory inpatient orders (70 per 100,000 population compared with a rate of 36 per 100,000 population for non-Māori) (Ministry of Health 2016). It is mostly young Pacific people who carry the burden of mental disorder, particularly severe forms of mental illness.

At the same time, we know that Pacific people are disproportionately low users of non-compulsory secondary mental health services (Ministry of Health 2012b). We have been told that fear of coming under the Mental Health Act is contributing to a lack of trust in mental health services generally, resulting in a person's condition escalating to the point where other people get concerned and resort to compulsion.

Once Pacific people come under the Mental Health Act, their families can struggle to understand what is going on and feel disconnected from their family member and the process. This is compounded by any language barriers the family may face. We have heard that this has the potential to change the relationship between the tangata whaiora/service user and their family.

Rates of compulsion under the Mental Health Act

(CRPD Articles 12, 14, 17 and NZBORA sections 9 and 11 are particularly relevant.)

Key points

- Numbers of people subject to community treatment orders has been increasing since 2005.
- The evidence for the effectiveness of community treatment orders is not strong in terms of hospital admissions and other relevant outcomes, although they may be effective for some individuals.
- There is wide variation across district health boards in their use of compulsory treatment orders (community and inpatient) and seclusion.
- Recovery requires informed risk taking, but the dominant operating model under the Mental Health Act is risk avoidance or management.

We would like your feedback on these issues:

10. Do you think the threshold for initiating, extending and moving people onto a compulsory treatment order is too low? Please comment.
11. What is the impact on individuals of being placed under a compulsory treatment order (inpatient or community) and on the therapeutic relationship between the tangata whaiora / service user and their clinician/clinical team?
12. Can the process of moving from voluntary treatment to compulsory assessment and treatment be improved? If so, how?
13. What role does access / lack of access to timely and appropriate services (inpatient and in the community), including early intervention and crisis resolution, play in people being placed under compulsory assessment and treatment?

The data suggests that the total number of people subject to compulsory treatment orders has increased since 2005, when more rigorous reporting procedures were put in place (Gordon and O’Brien 2014). Table 1 sets out the average number of compulsory treatment orders on a given day, per 100,000 population in New Zealand. The data comes from the Office of the Director of Mental Health’s annual reports. There has been an increase in community treatment orders, but not in inpatient treatment or leave orders, over the period 2005 to 2015. There is a view that the thresholds for initiating, extending and moving onto a community treatment order are too low and too easy to attain.

Table 1: Average number of compulsory treatment orders on a given day

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Community treatment orders (section 29)	60	58	61	63	61	77	85	77	80	85	86
Inpatient treatment orders (section 30)	17	16	15	13	14	14	19	13	12	14	14
Inpatient leave orders (s31)	5	6	5	5	4	6	7	4	3	4	3

A 2014 article compared the prevalence of community treatment order use in New Zealand over the period 2005 to 2011 with international prevalence rates. The article concludes that New Zealand’s community treatment order use is high by international comparisons, with New Zealand’s rates being higher than most Australian regions and other international comparator jurisdictions. The article argues that the relatively high rate of [community treatment order] use in New Zealand also raises questions of whether the measure is being appropriately targeted to a high needs group, or whether it has become a default option in defensively oriented mental health services. The fact that some regions show relatively low rates suggests there is scope to reduce overall use of CTOs. (O’Brien 2014)

Caution is needed when making direct comparisons in rates across jurisdictions because of differences in legislation and in the configuration of mental health services (eg, differences in the intensity of community services). However, it is still important to ask why community treatment orders seem to be used more frequently in New Zealand than in other jurisdictions with whom we often compare ourselves, and why the rates of community treatment orders have been increasing, particularly in light of the lack of scientific evidence for their efficacy (see below).

Evidence base for community treatment orders

Community treatment orders exist in 75 jurisdictions internationally (Rugkasa 2016). Internationally they are extensively used to prevent relapse and readmission. In New Zealand they were designed to reflect the shift to community treatment and away from hospital treatment.

A review of the most recent international literature concluded that the scientific evidence for community treatment orders is weak at best (Heun et al 2016). The findings from the key international studies on which this conclusion is based include:

- a number of non-randomised studies that have provided negative and conflicting results and thus have not provided sufficient evidence to support community treatment orders
- three independent, randomised control trials and a meta-analysis of their data that have shown no benefit of the community treatment order on the number of hospital admissions and other relevant outcomes (including service use, social functioning, mental state, homelessness, satisfaction with perceived coercion), with the exception that those on community treatment orders are less likely to fall victim to crime
- patients on a community treatment order showing even less adherence to depot injections (injection of antipsychotics) than those not on a community treatment order.

However, there is still some debate internationally about whether community treatment orders may work at an individual level in some tangata whaiora / service users (Heun et al 2016; Rugkasa 2016).

Variation between district health boards in rates of use of the Mental Health Act

There is wide variation across New Zealand’s 20 district health boards (DHBs) in their rates of compulsory assessment and treatment orders and seclusion events under the Mental Health Act. Table 2 sets out the range of rates for the 20 DHBs in 2015 (Ministry of Health 2016).

Table 2: DHB rates of compulsory assessment and treatment orders and seclusion events

Section of the Mental Health Act	Lowest DHB rate per 100,000 population	Highest DHB rate per 100,000 population
Acute assessment and treatment (section 11 of the Act)	6	18
Community treatment orders (section 29 of the Act)	47	164
Compulsory inpatient treatment orders (section 30 of the Act)	3	29
Seclusion events (section 71 of the Act)*	8	188

* Note that these rates relate to seclusion events in adult inpatient services, and not to seclusion events in forensic and intellectual disability inpatient services

The variation in rates of seclusion events across DHBs is likely to be due to a number of factors, including differences in seclusion practice, geographical variations in the prevalence and acuity of mental illness, ward design, staff numbers, experience and training, use of sedating psychotropic medication, and the frequent or prolonged

seclusion of one person, distorting seclusion figures over the 12-month period (Ministry of Health 2016).

The variable rates across DHBs raise concerns about whether people are being treated differently under the Mental Health Act across the country and the impact this may have on the quality of care.

Risk management vs recovery

New Zealand mental health services are committed to a culture of recovery. The Ministry of Health's Mental Health and Addiction Plan 2012–2017, *Rising to the Challenge*, describes recovery as 'the process of change through which people improve their health and wellness, live a self-directed life and strive to reach their full potential' (Ministry of Health 2012b). Mellsop et al state that the recovery model 'aims to put the consumer at the centre of management planning and to support recovery of autonomy, irrespective of persisting symptoms.' They go on to argue that 'good treatment will require judicious risk taking, in a context where risk prediction is difficult and imprecise' (Mellsop et al 2015). In other words, allowing tangata whaiora / service users to take some risks is an important part of their recovery.

There is a strong view that the current system around the Mental Health Act is oriented towards managing or avoiding risk, and that this is contributing to the relatively high rates of coercion and compulsion in New Zealand. Gledhill writes that the 'breadth of interpretation of "serious danger" in the legal criteria that govern compulsion under the Mental Health Act [refer to the definition of 'mental disorder'] seems to have expanded over time to become strongly preventive and predictive.' This may 'reflect the apparent increasingly risk-averse nature of society' (Gledhill 2013).

A number of clinicians have commented that it is difficult to take judicious risks in treatment planning in the current environment because of the lack of support for making the riskier choice. This over-riding emphasis on risk management and safety in the system may be compromising the functional recovery of tangata whaiora / service users under the Mental Health Act and preventing or delaying them from regaining autonomy (Mellsop et al 2015).

Seclusion and restraint

(CRPD Articles 12 and 14 and NZBORA sections 9 and 23 are particularly relevant.)

Key points

- New Zealand is working to further reduce (and eventually eliminate) seclusion in line with recommendations from the United Nations.
- This will require strong leadership, evidence-based seclusion reduction initiatives, ongoing workforce development and significant organisational commitment.

We would like your feedback on this issue:

14. What is your experience of seclusion and restraint? What do you think are the key changes needed to further reduce (and eventually eliminate) seclusion?

The ComRPD has recommended that New Zealand take immediate steps to eliminate the use of seclusion in medical facilities. The UN Working Group on Arbitrary Detention has also urged New Zealand authorities to eliminate this practice.

Seclusion is addressed in Part 6 of the Mental Health Act, which deals with patients' rights under the Act. Section 71 of the Act entitles every person who comes under the Act to the company of others, but it does allow a person to be placed in seclusion if certain conditions are met.

The Act does not address the manner and degree of restraint. This is set out in the Restraint Minimisation and Safe Practice Standards 2008 (the Standards). The Standards define seclusion and restraint and state that seclusion 'should be used for as short a time as possible and is best conceived as a safety mechanism rather than a therapeutic intervention or treatment.'

The Standards require services to record and monitor all instances of restraint and seclusion and subject their practices to rigorous internal and external review. Ministry of Health guidelines set out how restraint and seclusion events should be recorded to ensure national consistency (see also section 129 of the Mental Health Act). District inspectors have full and unrestricted access to seclusion registers.

Efforts to reduce the use of seclusion and restraint began in 2009, and since 2012 it has been a priority action of *Rising to the Challenge* (Ministry of Health 2012b), supported by Te Pou o te Whakaaro Nui. Between 2009 and 2015 the total number of people who experienced seclusion while receiving mental health treatment in an inpatient service decreased by 30 percent, and the total number of hours spent in seclusion decreased by 58 percent (Ministry of Health 2016).

Between 2014 and 2015 the use of seclusion steadied. While the total number of seclusion hours decreased by 6 percent, the total number of people secluded increased by 2 percent. In 2015, 754 people were secluded in adult inpatient services for a total of approximately 38,782 hours (Ministry of Health 2016).

The Ministry of Health anticipated this steadying. Most services in New Zealand, having successfully employed best-practice strategies to reduce their use of seclusion, are now entering a re-planning phase in which they are refining and refocusing seclusion reduction initiatives. Since 2009 there have been focused efforts to improve reporting on seclusion, which may partially explain the steadying of seclusion rates.

The continued reduction (and eventual elimination) of seclusion will require strong leadership, evidence-based seclusion reduction initiatives, ongoing workforce development and significant organisational commitment. The Ministry plans to update its guidance on the use of restrictive practices in mental health settings in 2016/17.

Indefinite form of compulsory treatment order

(CRPD Articles 12 and 14 and NZBORA sections 11 and 23 are particularly relevant.)

Key point

- The ability for compulsory treatment orders to become indefinite under the Mental Health Act raises human rights issues, including those relating to personal autonomy and recovery.

We would like your feedback on this issue:

15. What is your experience of and view on indefinite treatment orders?

After two consecutive six-month periods the next compulsory treatment order issued by the court can be in place for an indefinite time period (section 34[4]). However, the Mental Health Act imposes a duty on the responsible clinician to formally review a patient’s condition at least every six months. A patient, their family, a guardian, caregiver or GP, or a district inspector may at any stage also apply to the Review Tribunal for a review of the patient’s condition (section 79). A Review Tribunal decision can also be appealed.

Table 3 sets out the length of time people under the Mental Health Act remained subject to a community treatment order (section 29) or an inpatient order (section 30) for orders commenced between 2009 and 2013 (Ministry of Health 2016). The proportions for Māori and non-Māori are almost identical for section 29 and section 30 orders.

Table 3: Length of time people remain subject to a community treatment order (section 29) or an inpatient order (section 30)

Subject to community treatment order	Section 29	Section 30
Less than a year	73%	92.9%
1 to 2 years	7%	2.1%
More than 2 years	20%	5.0%

The ability for compulsory treatment orders to become indefinite with no requirement for regular review by the courts or Review Tribunal raises human rights issues, including the potential risks to a person’s personal autonomy and recovery, and whether there are sufficient protections in place to ensure a person is not detained under the Mental Health Act for longer than is necessary.

Appendix 1: Other relevant legislation and treaties

Te Tiriti o Waitangi (the Treaty of Waitangi) is the foundation document of the relationship between Māori and the Crown and is therefore a key point of reference when looking at administration of the Mental Health Act and how it relates to Māori. The relationship is based on the principles of partnership, participation and protection. In the health context:

- *partnership* involves working with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- *participation* requires Māori to be involved at all levels of the health and disability sector, including decision-making, planning, development and the delivery of health and disability services
- *protection* involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.⁵

The **United Nations Declaration on the Rights of Indigenous Peoples**, to which Aotearoa New Zealand is a signatory, sets out the minimum standards for the survival, dignity, wellbeing and rights of the world's indigenous peoples. The Declaration reflects existing international human rights standards and contains principles that are consistent with the duties and principles inherent in the Treaty of Waitangi.

The **Human Rights Act 1993** protects people in New Zealand from discrimination. The long title of the Act refers to 'the better protection of human rights in New Zealand in accordance with United Nations Covenants and Conventions on Human Rights'. To carry out this role, the Human Rights Commission has a number of specific functions, including the right to carry out inquiries into law or practice, if the Commission feels they may infringe human rights. Part 1A applies to discrimination in the public sector or by an agency performing a public function mandated by law, and incorporates the NZBORA balancing mechanism (sections 4 and 5 of NZBORA). A complaint to the Human Rights Commission about the use of the Mental Health Act is most likely to occur under Part 1A.

The **Health and Disability Commissioner Act 1994** establishes an individual complaint system based on the Code of Health and Disability Consumers' Rights (the Code of Rights). The Code of Rights provides for 10 rights that apply to 'every consumer' of health and disability services, including consumers of mental health services. The rights include the right to make an informed choice and give informed consent, the right to freedom from discrimination, and the right to dignity and independence.

⁵ Ministry of Health, *He Korowai Oranga: Māori Health Strategy*, www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

Clause 5 of the Code states that '[nothing] in the Code shall require a provider to act in breach of any legal obligation or duty imposed by any other enactment or prevents a provider doing an act authorised by any other enactment.' However the Code affirms the duty of providers to ensure clinical processes are exercised carefully and professionally and the human rights of patients are respected. As the purpose of Part 6 of the Mental Health Act (Patients' rights) is compatible with the Health and Disability Commissioner Act, the Acts can be seen as complementary (Human Rights Commission 2008).

The **Protection of Personal Property Rights (PPPR) Act 1988** sets out the most significant elaboration of legal capacity in New Zealand by allowing the court to enable various forms of substitute decision-making for adults who are unable to manage their own affairs due to impaired mental competence. The PPPR Act has an over-riding principle that all people must be treated equally and must be presumed to be competent to understand and make decisions on matters relating to their personal care and welfare, and to communicate those decisions, unless proven otherwise. 'The Court must first decide whether it has jurisdiction: that is, whether the subject of the order lacks competence. The Act defines capacity by providing a general definition of incompetence rather than listing disabling or incapacitating conditions.'⁶

Mental disorder may result in a lack of mental competence, thus bringing the individual within the PPPR Act jurisdiction. A patient may be subject to orders under both the Mental Health Act and the PPPR Act at the same time. However, mental disorder and the necessity for compulsory treatment does not mean there is a presumption of lack of competence, or that the PPPR Act would apply. The Court must consider whether a PPPR Act order is necessary in the circumstances. Where intervention is required, there may need to be consultation, for which the PPPR Act provides an appropriate mechanism.

The **Habeus Corpus Act 2001** enables persons detained in hospital to apply to the High Court for an urgent judicial inquiry into the legality of their detention under the Mental Health Act (writ of habeus corpus). This is an important, but rarely used, protection for people detained under the Mental Health Act.

⁶ Brookers Family Law, Mental Health (Compulsory Assessment and Treatment) Act 1992. N (19/4/11)2-11; PPIntro.02. Brookers and Thompson.

Appendix 2: CRPD articles of most relevance to discussions about compliance with the Mental Health Act

Article 12: Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.
5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

Article 14: Liberty and security of the person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
 - a) Enjoy the right to liberty and security of person;
 - b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

Article 17: Protecting the integrity of the person

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

Article 25: Health

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

- a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- c) Provide these health services as close as possible to people's own communities, including in rural areas;
- d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

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