changing minds
for better mental health
Te Pae Tawhiti o te Hinengaro

Ministry of Health Consultation on Draft Guidelines on the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992

Submission on behalf of Balance Aotearoa,
Changing Minds and Platform Trust

Tuia i runga

Tuia i raro

Tuia i roto

Tuia i waho

Tuia te here tāngata kia kōkiritia tonutia tātou ki te pae tawhiti o te whakaaro

arā, ahakoa ko wai, ahakoa nō hea, ahakoa ngā wheako, ahakoa te ara i takahia ai e tātou, he tāngata te mea nui i tēnei ao

Weave all that is above, weave all that is below, weave all that is within, weave all that is out. Weave together the many, to continue striving forward in bringing life to what is most important in this word, the people. Regardless of who we are, where we're from, our experiences and journey taken, we are united as the people.

Kaitiakitanga – protecting the people

He mana tō te kupu, nā reira me kōrero tahi tātou

Words hold great power, therefore let us speak together.

Nā te whānau kotahi nei, nā

Balance Aotearoa *Changing Minds* *Platform Trust*

Context and process

We welcome the opportunity to provide feedback on behalf of our organisations to the Ministry's consultation on these significant revisions to the Mental Health Act Guidelines.

The Mental Health Act itself is outdated and not fit for purpose in a society and system focused on wellbeing, recovery and self-determination. We believe the revisions to the Guidelines being made currently should pave the way for the eventual changes we would like to see in the Act. While that major legislative change is underway, these revisions are essential in order to improve the care and support of individuals and whānau subjected to the use of the Act.

The revisions are overdue and much-needed and, therefore, should be implemented with urgency. Despite the tight timeframe over the holiday period, we have invited and received feedback from our networks which have informed this response.

We hope that the Ministry has sought views from a wider range of stakeholders who can contribute to ongoing improvements to the Guidelines. In particular, incorporating a Police perspective in the Guidelines could make a significant improvement to the lives of service users and those supporting them.

Police frequently find themselves in the front line of mental health crises, walking a tightrope between rights and safety, frustrated by the Act and limited options for support or alternatives.

We are reassured that the Ministry will continue to monitor and amend the Guidelines in the intervening years before the Act is repealed, in the context of emerging issues such as the findings of Wai 2575. Given the rapidly changing landscape we would like an undertaking that, while repeal/replacement of the 1992 Act is pending, the existing Guidelines should be updated at least annually. We will continue to gather the views of our networks over the coming months to feed into that next iteration.

When the revised Guidelines are published, the Ministry needs to actively promote the new version to ensure that they inform all decision-making in respect to the Act. Specifically, we want to see comprehensive planned communication with relevant service providers and professionals to draw attention to those essential revisions relating to human rights, mana, self-determination and supported decision-making.

This should also highlight the status of the Guidelines – that they are not an optional extra or to be used selectively, but are the means of ensuring the Act is applied with genuine intent to promote individual wellbeing and recovery.

Given the extended timeframe expected before the current Act is repealed, we would also like to see independent assessment of the impact of the revised Guidelines. This is also an area in which the Mental Health and Wellbeing Commission should play a role.

General comments on the revised Guidelines

We welcome the changes that have been incorporated into the draft revisions, making the Guidelines more relevant and accessible, and taking vital and overdue steps to promote protection of individual rights, freedoms and mana.

The Guidelines reflect – and should also encourage – an evolving environment very different to that of 1991. Modernised Guidelines must be an enabler for supportive person-centred services that are active in reviewing their own practices, rather than ‘managing’ an individual with a ‘disorder’ or who is seen as treatment resistant or unwilling to engage.

These Guidelines are an important tool in promoting change, innovation and reform of practice as well as ensuring consistent minimum standards. It would be helpful to incorporate a brief foreword that provides that context for service providers. This should also reflect the need to consider the wider societal impacts on mental wellbeing and recovery inherent in the wider policy and system changes underway.

We congratulate the Ministry on the detail and focus introduced around respect for culture/culturally responsive care (including gender diversity and sexual orientation), the obligation to involve and consult whānau and informed consent. The strengthening of the underpinning principles of least restrictive intervention, and supported decision-making, including the use of advance directives, are critical improvements.

In particular, we are encouraged by the addition of the new first chapter ’Taking a Human Rights Approach’ which provides the fundamental framework for administering an obsolete Act in the 21st century.

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Framing the Act in the human rights approach is essential, but we acknowledge that the Act and associated Guidelines still need to be workable ahead of wider legislative changes. Preserving human rights when using laws that allow compulsory assessment and treatment presents enormous legal, ethical and moral challenges, and the Ministry has taken important steps to considering some of those challenges in these revisions.

We note that the Ministry has offered to act as an adviser in reconciling the dichotomy between rights and coercion. As an upholder of the legislation, this could present the Ministry with its own challenges. This is a role that would best sit with the Health and Disability Commission, working alongside the Mental Health and Wellbeing Commission.

As the new Commission take shape and its functions are finalised, we expect that it will also have a role, in conjunction with the Ministry and the Mental Health Review Tribunal, in holding service providers to account, being able to demonstrate that decision-making under the Act is at all times in the best interests of the individual and their whanau.

Given the new emphasis on upholding human rights and Te Tiriti O Waitangi, having skilled advocates who can support changes in practice will be vital. We believe the Ministry and the Mental Health Commission should take immediate steps to consider how an effective consumer advocacy and protection service can be procured or established as an integral part of implementing of the new guidelines.

Access to informed and independent consumer and whānau advocacy for those affected by the Act is a major gap in our system, with very limited resourcing. It is a service that would not only benefit individuals and whanau, but service providers and officials in applying these strengthened guidelines. We believe the Ministry should work with the Health and Disability Commission and the Mental Health and Wellbeing Commission to consider how an effective consumer advocacy and protection service can be procured or established in the near future.

We also note that there is no matauranga Māori definition of 'mental illness' in the Guidelines. The right to define meaning is essential to tino rangatiratanga. We suggest that the Ministry of Health undertakes to work with tangata whaiora and Iwi nationally to develop a matauranga Māori definition of 'mental illness' and that the intention to carry out this work is signalled in the revised Guidelines.

The Guidelines are inevitably complex. We would also like to see some simplification of sections and improved cross-referencing of related content to improve usability. Given the scope and tight timeframe, we recognise that some of that work may need to be taken foreword to the subsequent iteration.

Our recommended amendments to the proposed draft

Introduction Page 1

Bullet point one notes that one of the key changes and emerging issues that has prompted revision of the Guidelines is 'the growing influence of rights-based approaches and how these can be better promoted within the parameters of the current Mental Health Act'.

We would like to see that wording replaced with '***there is a requirement under international law for New Zealand to uphold the same human rights for all citizens without discrimination on the basis of an actual or perceived disability'.***

Consistently and justly navigating the inherent tension between fundamental human rights and the coercion and restricted freedom the Act permits is critical. In the potentially lengthy period before the Act is repealed and replaced that tension is likely to be a recurrent source of debate and distress. Any additional clarification here about how that tension could be managed would be welcome.

This is also an opportunity to place a stronger emphasis in the Introduction on engagement with people and communities, and constructive responses to disagreement and dissent. The importance of enhanced communication and engagement needs to be more overtly at the heart of how we respond to mental distress, and application of the Mental Health Act overall.

The Introduction offers the support of the Office of the Director of Mental Health and Addiction in using the Guidelines. Further details about how the MoH, the Health and Disability Commission, Mental Health and Wellbeing Commission and the Mental Health Review Tribunal will work together as advisers and arbiters for users of the Guidelines will be important.

On the issue of how to consider the use of the Act in a human rights context, we recommend referencing Ministry of Health's document "The Mental Health Act and Human Rights – A discussion document: https://www.health.govt.nz/system/files/documents/pages/mental_health_and_human_rights_discussion_document_0.docx

Balancing individual rights with professional and legal duties Page 2

We believe the overall shift in emphasis to a human rights-based approach should be made more explicit in this part of the Introduction, with wording to that effect highlighted immediately under this heading: '***At all times self-determination is paramount and the human rights of the individual must be preserved***.'

The current text states that the 'Mental Health Act is an interface between medical treatment and legal intervention, and it significantly affects the rights and freedoms of people who use services.'

We recommend strengthening and clarification of this statement to read: '***The Mental Health Act has evolved as an interface between medical treatment and legal intervention. It overrides the rights that are enshrined in international law through the United Nations Convention on the Rights of Persons with Disabilities (CRPD), to which New Zealand is a signatory. This will be an essential consideration in the review of the Act itself. In the interim, administration of the Act must always be considered alongside our country's human rights obligations.'***

Medical treatment provided should be of a form - supported by robust evidence, and taking into account cultural identity and other relevant factors - that is expected to lead to improvement in an individual's condition or prevent its worsening. The primary objective must be ongoing recovery with avoidance of, or discharge from, detention and continued access to a full range of treatment and support options. These must be regarded as paramount obligations, consequent to the extraordinary steps of removing a person's human rights.

It would be helpful to include reference in this introductory section to the CRPD text, which underpins the principles of self-determination and informed consent that are the basis of

many of the revisions to the Guidelines.
https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

Reference to the CRPD General Comment #1 adopted in 2014 should also be included:
http://daccess-ods.un.org/access.nsf/Get?Open&DS=CRPD/C/GC/1&Lang=E

Including the text of paragraphs 9, 15 and 42 of General Comment #1 as a box or an Appendix to the Guidelines would be helpful. These paragraphs, in particular, highlight the dichotomy between our outdated Mental Health Act and our international treaty obligations. The relevant text is:

CRPD General Comment #1

Paragraph 9: *All persons with disabilities, including those with physical, mental, intellectual or sensory impairments, can be affected by denial of legal capacity and substitute decision- making. However, persons with cognitive or psychosocial disabilities have been, and still are, disproportionately affected by substitute decision-making regimes and denial of legal capacity.*

The Committee reaffirms that a person's status as a person with a disability or the existence of an impairment (including a physical or sensory impairment) must never be grounds for denying legal capacity or any of the rights provided for in article 12. All practices that in purpose or effect violate article 12 must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.

Paragraph 15. *In most of the State party reports that the Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. This is decided simply on the basis of the diagnosis of an impairment (status approach), or where a person makes a decision that is considered to have negative consequences (outcome approach), or where a person's decision-making skills are considered to be deficient (functional approach).*

The functional approach attempts to assess mental capacity and deny legal capacity accordingly. It is often based on whether a person can understand the nature and consequences of a decision and/or whether he or she can use or weigh the relevant information. This approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right — the right to equal recognition before the law.

In all of those approaches, a person's disability and/or decision- making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a *person before the law. Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.*

Paragraph 42. *As has been stated by the Committee in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16).*

This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention. States parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; must ensure that accurate and accessible information is provided about service options and that non-medical approaches are made available; and must provide access to independent support.

States parties have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The Committee recommends that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned.

Chapter 1 Taking a Human Rights Approach

We congratulate the Ministry on inclusion of this new chapter and framing the Guidelines in this human rights context.

The communities we collectively serve have the same human rights as every other person. These rights are detailed in the United Nations Convention on the Rights of Persons with a Disability (CPRD) which New Zealand ratified in 2008, making successive governments accountable under international law for carrying out its requirements.

We believe all people should be protected from the harm caused by involuntary medical treatment, and detention, incarceration, physical force, restraint, and solitary confinement on the basis of an "actual or perceived disability" (mental distress or mental disorder).

The changes are designed to ensure people who use the Act will significantly increase the weight given to the human rights of people being placed under the Act. This should be made explicit in communication to service providers in relation to the new Guidelines.

Section 1.2 Rights-based and recovery approaches to care and treatment Page 6

The proposed draft text acknowledges the ‘tension’ between human rights and freedoms ‘and the compulsion, or coercion expressed within the Act.’

We would like that acknowledgment strengthened and clarified with additional wording that ‘***the provisions within the Act for coercion and compulsory detention and treatment deprive people of essential human rights and fundamental freedoms.’***

This highlights the obligation of those making decisions under the Act to ensure protection of, or restoration of, a person’s full human rights and fundamental freedoms, within the earliest possible timeframe.

The next paragraph states that ‘there is scope for services and individuals operating under the current Act, to more closely align their decision-making and clinical practice with domestic and international human rights obligations’.

This should be strengthened to state that: ‘***Service providers and individuals operating under the Act must ensure their decision-making and clinical practice also takes full account of domestic and international human rights obligations.’***

Section 1.2.1 Human rights and the Mental Health Act Page 7

On the issue of informed consent and supported decision-making, we believe there should be a reference again in this section to the CRPD General Comment #1, specifically Items 9, 15, and 42. (c.f. our comments in relation to the Introduction).

Section 1.2.2 Least restrictive approach Page 8

We applaud the increased emphasis on a least restrictive approach in the draft revisions.

We believe there is some ambiguity in the paragraph: ‘Compulsory treatment does not mean that people lose their human rights. Rather, decisions about compulsory treatment require clinicians to balance an individual’s rights against the need for coercive interventions as permitted under the Mental Health Act.’

We recommend amending this paragraph to again refer to the tension between respective statutory requirements - for example: ‘***Compulsory treatment under the Act overrides and is at odds with the fundamental human rights set out in the CRPD. However, those rights, inherent in being human, still remain in all circumstances and must be considered paramount in decision-making.***

We also propose that the following new paragraph be added at the end of this section.

‘Restorative justice

When a person is subjected to substituted decision-making using the Act, plans must be made to assist them to come to terms with, and regain, the loss of their sense of personhood and autonomy that often results within the earliest possible timeframe. A restorative justice approach should be used to enable mutual understanding of the impacts of the event where rights were overridden.’

Too many people, particularly Māori, access services too late or access services that may not reflect their world view and are held compulsorily as a result.

A co-constructed review should bring together the person, their whānau, clinical and other support to determine what processes or interventions might lead to better outcomes if the person becomes distressed again in the future. This review should also require the responsible clinician to consider with the person and their whānau the pathway of support and options available prior to the person becoming so unwell that led to them being placed under the Act.

These reviews should be incorporated as required practice, with future monitoring by the Mental Health and Wellbeing Commission.

Section 1.3 Supported decision-making Page 9

The final paragraph of this section states that 'New Zealand is in the early stages of considering how to implement supported decision-making, and the legal mechanisms to enable and/or enforce it'.

This implies limited understanding of the current and emerging importance of supported decision-making and that it may be optional. With rangatiratanga at the heart of these Guidelines, supported decision-making should always be the norm, with exceptions only in cases where consent is not possible.

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists has produced a position paper to educate consumers, families and clinicians about the principles of supported decision-making which could be referenced here: https://www.ranzcp.org/files/branches/victoria/enabling-supported-decision-making-vic-branch-posi.aspx

It highlights that supported decision-making is a collaborative approach to support an individual in making their decisions and is not shared decision-making or substitute decision-making.

Section 1.3.4 Right to support person Page 11

We believe there should there be a statutory requirement for the provision of an 'appropriate adult' (as is the case in the UK) for vulnerable adults who are under the Act or in detention with Police. The role of this appropriate adult is to safeguard the rights and welfare of vulnerable people who are suspected of a criminal offence, ensuring that they are treated fairly and able to participate effectively.

1.3.3 Recovery planning Page 11

The inclusion of advice on transition between services is welcome. We know, as highlighted by the reference to the Office of the Auditor General's report, that this is a major area of weakness in our current services.

In addition to the requirement to undertake regular recovery planning, we recommend including a statement :'***that this planning takes place in a cross-sector and cross-service multi-disciplinary team environment and that individuals and whānau have access to a named lead or advocate who will oversee and co-ordinate integration and transition between services'.***

The Guidelines need to encourage approaches that consider and address the wider societal factors that contribute to ill health, wellbeing and recovery. Explicit mention of wider factors such as housing, income and employment should be made in relation to recovery planning.

2.1.5 'Poses a serious danger to the health or safety of that person or of others' Page 21
The final paragraph in this section states that 'To assist balancing the potential for harm against the need for compulsory treatment, clinicians <u>may</u> want to examine the protective factors and strengths posed by the person <u>in question</u>. That is, what situational circumstances and conditions are going to protect the person and keep them safe.'

We recommend a change to this paragraph in the spirit of self-determination and active involvement of whānau that are now fundamental to the Guidelines to read: '***To assist in minimising, if not eliminating the potential for harm against the decision for compulsory treatment, clinicians <u>must</u> examine the protective factors and strengths posed by the person being supported. That is, what situational circumstances and conditions are going to protect the person and keep them safe. The primary source of this information must be the person being supported and, if they so choose, their family and whānau.'***

Section 4.1.1 Culturally responsive care Page 31
We welcome inclusion of the requirement to carry out a cultural assessment.

Te Whare Tapa Whā [note macron in heading]
It is worth noting in this section that the Te Whare Tapa Whā model was designed for tauiwi – non-Māori - to gain an insight of understanding hauora Māori concepts.

The cross-referencing to the SACAT and its requirement to consider an individual's mana is a positive addition. We believe the final paragraph should be strengthened further to align with the Guidelines' rightful increased focus on cultural safety and cultural consciousness.

Specifically we would like to see the removal of the word 'may' in relation to Te Tiriti o Waitangi obligations so that it reads: '***application of the principles of Te Tiriti o Waitangi necessitate that providers deliver care in such a manner that the mana of whānau and right to tino-rangatiratanga is prioritised and ultimately upheld'.***

We recommend including reference to resources from the HQSC 's mental health and addiction quality improvement programme's Māori advisory group: https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/Resources/Maori-advisory-group-tools-Jan-2019.docx

Section 4.1.3 'Proper respect for the person's cultural and ethnic identity, language and religious or ethical beliefs' Page 36
The explicit recognition of an individual's rights regardless of gender or sexual orientation and the uniqueness of the individual is a vital addition to the Guidelines.

At times professionals and providers may need additional expertise to fully reflect the needs of individuals, particularly in understanding and addressing intersectionality. In such situations, services could benefit from seeking independent advice or advocacy support from an appropriate consumer network or NGO.

We encourage the Ministry to include this recommendation in the Guidelines.

Section 7 Part 2 Compulsory treatment orders Page 62
New Zealand mental health services continue to be high users of measures of compulsion by international standards. We urge an investigation into the major variations between New Zealand DHBs in the use of compulsory treatment and seclusion and the reasons behind those variations. This assessment could be signalled in the Guidelines and led by the Mental Health and Wellbeing Commission.

This section also provides a further opportunity to highlight the societal elements in relation to decision-making under the Act. Greater responsibility to ensure people have good options in aspects of their life such as housing, connection and employment could see a reduction in the number of people being treated compulsorily.

Section 11 Part 6 Rights of patients and proposed patients Page 84
We need to make more overt the state's obligations around reciprocity where people are required to receive treatment under the Act. For example, we need to support and enhance quality improvement to put hospitality into practice, create positive cultures, and ensure health promoting environments in inpatient units – and develop alternatives.
Section 11.8 Right to company and seclusion Page 88

On the issue of eliminating seclusion we recommend referencing the HQSC's literature review and associated project information:
https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/publications-and-resources/publication/3414/

https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/programme/

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