

Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992

DRAFT

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Introduction

These guidelines are intended to support the effective and lawful use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (referred to hereafter as ‘the Act’ or ‘the Mental Health Act’). They are written for clinical staff, district inspectors, and any other parties who administer or work within the legal or clinical framework of the Mental Health Act. Families, service users, and members of the public may also find benefit in these guidelines, however, they are largely written for those who administer the legislation in practice.

They were last updated in 2012. A number of key changes and emerging issues have prompted the revision of these Guidelines. In particular:

- the growing influence of rights-based approaches and how these can be better promoted within the parameters of the current Mental Health Act
- The impact of the Mental Health and Addiction Inquiry, particularly feedback from people with lived experience and families and whānau on how they experience current administration of the Act
- The need to give greater emphasis to our obligations under Te Tiriti o Waitangi.

These issues are developed in a new chapter 1.

The Mental Health Act – a legislative framework for compulsory assessment and treatment

The Mental Health Act provides a legal framework and sets out the narrow circumstances in which people may be subject to compulsory (psychiatric) assessment and treatment. The Act provides treatment for patients with a mental disorder (and those being assessed as proposed patients) who are assessed as a serious danger to the health or safety of that person or of others or as having seriously diminished capacity to take care of themselves.

The Mental Health Act should be thought of as an entry point to services for people experiencing a mental illness who are unwilling or unable to consent to voluntary treatment; where the person may cause serious harm to themselves or others; or is gravely incapable of caring for themselves. Compulsory treatment under the Act provides an opportunity for a person experiencing a serious mental illness to live well in the community and regain self-determination for their health care.

The Mental Health Act is written in a way that favours community treatment, while still providing for those who require hospital-level (inpatient) treatment. This is promoted through a focus on regular consultation between patients, their family, whānau, guardian, principal care giver, or significant support network, and clinicians; and the legal framework and clinical practice, which pursues minimally restrictive treatment in the community.

Balancing individual rights with professional and legal duties

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. Intervention under the Mental Health Act often raises concerns for the person placed under the Act and their supporters about human rights and privacy.

Clinicians must consider the balance between these interests and apply professional and ethical principles when using the Mental Health Act. Consistent with the New Zealand Bill of Rights Act 1992 (NZBORA) and with the intent of the Mental Health Act, treatment should be provided in the least restrictive way possible.

No piece of legislation can be framed in such a way that all circumstances that could possibly arise are precisely covered.

If there are two interpretations available and it is a case of needing to decide which to adopt, the purpose can influence which of the available interpretations to adopt, but the statutory text needs to be adhered to, as good intentions do not permit actions which are otherwise unlawful.

The Office of the Director of Mental Health and Addiction are always available to assist services in making these decisions.

Additional guidance

Finally, to complement the information provided in this set of guidelines, the Ministry of Health has issued a range of guidance material to assist clinicians and administrators to best fulfil their statutory roles, and to assist in the appointment of suitable candidates to statutory roles. The following guidance documents should be read in conjunction with these guidelines:

- *Guidelines for the Role and Function of Directors of Area Mental Health Services* (Ministry of Health, 2012)
- *Guidelines for the Role and Function of Duly Authorised Officers* (Ministry of Health, 2012)
- *Competencies for the Role and Function of Responsible Clinicians under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health, 2001)
- *Guidelines for Medical Practitioners using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health, 2000).
- *Guidelines for the Role and Function of District Inspectors under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health, 2012)

A full list of related Ministry of Health publications is contained in Appendix 1.

1 Taking a human rights approach

Scrutiny of the Mental Health Act in recent years has highlighted that New Zealand’s mental health law is out of step with modern approaches to compulsory mental health assessment and treatment. There are also stark inequities in the way that the Act is applied to Māori and Pacific people.

He Ara Oranga: the report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga) recommended that the Mental Health Act be replaced with new legislation that:

‘reflects a human rights approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment’ (recommendation 34).¹

In 2019 the Government agreed to repeal and replace the Mental Health Act. Work on this has begun, but until the Mental Health Act is replaced with new legislation it is our collective responsibility to ensure the current Act is applied in a way that respects and promotes a person’s rights and places human rights principles at the centre of service provision to the extent that it is possible within the current legislative framework.

This section looks at what a human rights approach might mean for the application of the Mental Health Act and makes explicit the obligation to uphold the principles of Te Tiriti o Waitangi/the Treaty of Waitangi. In particular, these revised guidelines introduce the concept of supported decision-making.

The purpose of this information is to set expectations and outline how clinicians applying the Mental Health Act can align their practice with a human rights approach and ensure that they are responsive to Māori patients.

1.1 Te Tiriti o Waitangi/The Treaty of Waitangi

The revision of these guidelines highlights the importance of meeting obligations under Te Tiriti o Waitangi (the Treaty of Waitangi). As steward and kaitiaki of the health and disability system (article I), the Ministry of Health has a responsibility to enable Māori to exercise their authority (article II) and enable the health system to achieve equity in health and wellness for Māori (article III) in ways that enable Māori to live and thrive as Māori (the Ritenga Māori Declaration)² (Ministry of Health 2019). Under Te Tiriti o

¹ Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.

² The Ritenga Māori declaration (often commonly referred to as the ‘fourth article’) was drafted in te reo Māori and read out during discussions with rangatira concerning Te Tiriti o Waitangi.

Waitangi, the Ministry of Health and all publicly funded health services are obligated to acknowledge and utilise Te Tiriti o Waitangi articles and principles in their policies and practices.

In 2016, the Waitangi Tribunal commenced the *Health Services and Outcomes Kaupapa Inquiry* (Wai 2575) into nationally significant health issues for Māori. Stage 1 has focused on claims relating to the primary health care system (report released in 2019) and has made substantial recommendations for change.³ The Government is currently formulating its response. Stage 2 of the Inquiry has commenced and will investigate themes of national significance relating to mental health (including suicide and self-harm), disabilities and alcohol and substance misuse. Stage 2 findings and recommendations may impact on future iterations of these guidelines.

Stage 1 recommendations include changes to legislation and policies to give effect to Te Tiriti o Waitangi principles, with a clear objective for the health sector to achieve equitable outcomes for Māori. The Tribunal found the following Te Tiriti o Waitangi principles were applicable to their inquiry. The principles have been reflected in the Ministry of Health's draft Treaty Framework/Māori Health Action Plan. Where possible, these guidelines will reference the principles so that they can be considered when having to take clinical and/or legal action under the Mental Health Act.

- 'Tino rangatiratanga' underpins the principles identified in Te Tiriti. It is often translated as 'self-determination' or 'sovereignty'. What this means is that Māori are guaranteed self-determination and mana motuhake (the right to be Māori, and to live on Māori terms in accordance with Māori philosophies, values, and practices) in the design, delivery and monitoring of health and disability services.
- 'Partnership' is recognised as a relationship between the Crown and Māori; acting with respect towards one another, working together, and being flexible to different structures where organisations are not meeting the needs of one another. Partnership requires Crown and Māori to work in partnership in the governance, design, delivering and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the health and disability system for Māori.
- 'Active protection' requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents and its Treaty partner are well informed on the extent, and nature of, both Māori health outcomes and efforts to achieve Māori health equity.
- 'Options' requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- 'Equity' requires the Crown to commit to achieving equitable health outcomes for Māori.

It provided for the protection of religious freedom and the protection of traditional spirituality and knowledge.

³ Waitangi Tribunal. (2019). *Hauora: Report on stage one of the health services and outcomes kaupapa inquiry*. Pre-publication version. Wellington: Printlink.

Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

The above principles are interrelated and aim to strengthen effective health pathways, equitable outcomes, and overall satisfaction within the health and disability system for all. We see that Māori continue to be disproportionately placed under the Mental Health Act, receiving community compulsory treatment orders under the Act at four times the rate of non-Māori, per 100,000 population.⁴ These inequities need to be made more visible and action taken to address them. Multiple government agencies, organisations, and sectors must work together to improve health outcomes, as it is the responsibility of all New Zealanders to be actively fulfilling the agreements made between the Crown and Māori.

You can visit the following website for more information and guidance about the Health Services and Outcomes Inquiry (2019).⁵

Sections 5 and 65 of the Mental Health Act emphasise the statutory importance of incorporating cultural considerations into processes and decisions under the Act, including proper recognition of the importance to the patient's wellbeing of the patient's ties with whānau, hapu and iwi.

1.2 Rights-based and recovery approaches to care and treatment

Both rights-based and 'recovery' approaches to mental health are seen as good practice in modern mental health and addiction care. A rights-based approach to mental health is directed towards promoting and protecting human rights. A 'recovery' approach means working towards supporting an individual to live a self-directed life and strive to reach their full potential.⁶ Both emphasise the active participation of those living with a mental health condition in decisions about their care and treatment. The report of the Mental Health and Addiction Inquiry, He Ara Oranga, also highlighted rights-based and recovery approaches as a crucial aspect of an improved mental health system and new mental health legislation.⁷

New Zealand is a signatory to a number of international agreements that are relevant to the rights of people receiving compulsory mental health treatment, including:

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

⁴ Ministry of Health. (2019) Office of the Director of Mental Health and Addiction Services Annual Report 2017. Wellington: Ministry of Health.

⁵ https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_150429818/Hauora%20Pre-PubW.pdf

⁶ *Ler's Get Real*. Te Pou and Ministry of Health (2018). <https://www.tepou.co.nz/uploads/files/resource-assets/Refreshed%20Let%27s%20Get%20Real%20-%20final.pdf>

⁷ *He Ara Oranga: the report of the Government Inquiry into Mental Health and Addiction*. (November 2018). <https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/>

- the Convention Against Torture & Cruel, Inhuman or Degrading Treatment or Punishment
- the Declaration on the Rights of Indigenous Peoples
- United Nations Convention on the Rights of the Child.

In line with the CRPD, there is an international movement towards greater recognition of the rights of disabled people, including people with psychosocial disabilities. The CRPD adopts a ‘social model’ of disability, which means that disability is not attributed to the individual. Rather, “disability” is the disadvantage that results from barriers created by the social, political and physical environment, which restricts people in exercising their human rights.

The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by people with disabilities, including psychosocial disabilities. There is a tension between this objective and the compulsion, or coercion expressed within the Act.

While some of these tensions will need to be addressed through the repeal and replacement of the Mental Health Act, 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.

With regard to compulsory treatment, key CRPD rights to be considered are:

- the freedom to make your own choices (Article 3A)
- equal recognition of disabled people before the law (Article 12)
- the right to be free and safe and not deprived of freedom arbitrarily (Article 14)
- treating disabled people as people first (Article 17)
- the right to good health and health services ‘on the basis of free and informed consent’ (Article 25).

Article 12 of the Disabilities Convention (equal recognition before the law) makes clear that people with mental illness have the right to control decisions about their lives with whatever kinds of support they require and that countries are obliged to establish the arrangements to make this possible. This includes the right to give consent for medical treatment.

Article 12 also makes clear that countries, including New Zealand, should have safeguards in place for people who require another person to present their will and preferences when a decision needs to be made, to ensure they are protected. Generally, these requirements under Article 12 are referred to as supported decision-making.

Over December 2016 to March 2017, the Ministry of Health and Balance Aotearoa undertook targeted consultation on a discussion document, *The Mental Health Act and Human Rights*. The document sought feedback on how the Mental Health Act aligns with human rights obligations under NZBORA and the CRPD. It also sought feedback on how implementation of the Mental Health Act affects those who are placed under the Act and their families and whānau and how it could be improved. There was a high

level of consistency in the feedback on the key concerns and priorities for improvement.⁸

- Increase recognition of the views and preferences of service users.
- Improve family/whānau consultation.
- People want greater choice in treatment options – not just medication.
- The risk averse culture around mental illness in New Zealand is in conflict with the ‘recovery model’ of mental health care and treatment.
- A lack of access to early intervention services is seen as contributing to rates of compulsory assessment and treatment.
- Improve cultural responsiveness, access to cultural services and expand the Māori health workforce.
- Give greater priority to reducing and eliminating seclusion and restraint.

1.2.1 Human rights and the Mental Health Act

NZBORA and the Human Rights Act 1993 give expression to New Zealand’s international obligations in domestic law. The Health and Disability Services Consumers’ Code of Rights Regulations 1996 (Code of Rights) is the mechanism to protect people’s rights in relation to health and disability care.

NZBORA rights most relevant to the operation of the Mental Health Act include: the right not to be subject to torture, or to cruel or degrading or disproportionately severe treatment or punishment (section 9); the right to refuse to undergo medical treatment (section 11); and the right for everyone deprived of liberty to be treated with *humanity* and with *respect for the inherent dignity of the person* (section 23).

The Code of Rights sets out 10 rights that apply to “every consumer” of health and disability services, including to the right to make an informed choice and give informed consent, freedom from discrimination and to dignity and independence.

However the rights as 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 persons’ rights to be restricted to protect themselves, or the rights of others. 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.”⁹

Clause 5 of the Code of Rights 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.” This includes the

⁸ Submissions on the *Mental Health Act and Human Rights* discussion document – An analysis. Ministry of Health 2017. <https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment>

⁹ John Dawson in *Health Law in New Zealand*, PDG Skegg, Ron Paterson (General Editors), Thomson Reuters New Zealand Ltd, 2015

Mental Health Act. However, the Code of Rights affirms the duty of all health and disability service providers to ensure that clinical processes are exercised carefully and professionally and the human rights of patients are respected.

The Mental Health Act limits the right to refuse to undergo medical treatment. Because of this significant infringement on individual autonomy and freedom, the Mental Health Act includes a number of safeguards and independent monitoring mechanisms to protect patients' rights. These are discussed below in chapter 11.

1.2.2 Least restrictive approach

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. To avoid unnecessarily infringing on people's human rights, compulsory treatment must be provided in a manner that is consistent with NZBORA and the Code of Rights to the greatest extent possible, and in the least restrictive way.

The Royal Australian & New Zealand College of Psychiatrist's (RANZCP) Code of Ethics states that 'Psychiatrists shall respect the humanity, dignity and autonomy of all patients'¹⁰. This is consistent with the human rights affirmed in the CRPD.

Principle One goes on to say:

1.3 Psychiatrists shall be especially mindful of respect for autonomy given their statutory role in treating a proportion of their patients compulsorily. Compulsory treatment may be justified where a less restrictive intervention cannot achieve safe and adequate care; its purpose is ultimately to promote and re-establish patients' autonomy and welfare.¹¹

1.3 Supported decision-making

Supported decision-making is a central concept in the CRPD, which places an obligation on state parties to ensure people have the support needed to, amongst other things, make decisions about their medical treatment (Article 12).

Supported decision-making is the process of providing a person with the help they need to make decisions about their treatment, care or support. It comprises various informal and formal support arrangements which give priority to a person's views, will and preferences in decision-making.

In supported decision-making, expression of a person's 'will and preferences' takes the place of 'best interests'.

A supported decision-making approach assumes that all adults (with limited exceptions) have some level of ability to make decisions but may need varying levels of

¹⁰ RANZCP *Code of Ethics*. (Principle One. 2018).

https://www.ranzcp.org/files/about_us/code-of-ethics.aspx

¹¹ *Ibid.*

support to do this.¹² It also acknowledges that decision-making capacity is not something that people simply have or do not have. People may have a certain degree of capacity, which may change at different times and in relation to different issues.

Supported decision-making contrasts with substitute decision-making, where someone else is given authority to make decisions about a person's treatment, and shared decision-making, which describes person-centred approaches where people and their treating team make decisions together about treatment¹³.

A supported decision-making approach is consistent with the principles of 'active protection', 'partnership', and 'tino rangatiratanga' under Te Tiriti o Waitangi.

Some international studies have explored the use of supported decision-making in people with serious mental illness¹⁴. The studies have focussed on the need for, rather than the outcomes of, supported decision-making. They suggest that supported decision-making is viewed by patients and their caregivers as an acceptable and potentially superior alternative to substitute decision-making. An evaluation of these studies found that supported decision-making has the potential to meaningfully improve the well-being and quality of life of persons with serious mental illness.¹⁵

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. A literature review commissioned by the Office for Disability Issues explores current thinking, practice and research into support for disabled people's exercise of their legal capacity, including supported decision making.¹⁶

1.3.1 Supported decision-making under the Mental Health Act

The RANZCP Code of Ethics recognises the need to "support the decision-making of a patient with impaired capacity so that, where possible, a decision can be validly made" (5.6). The Code of Ethics also requires its members to "respect the rights, will and preferences of the patient, and take into account any advance directive" when seeking consent from a substitute decision-maker (5.7).¹⁷

In the context of the Mental Health Act, supported decision-making should be viewed as an attempt to provide care in the least restrictive way by promoting the self-determination of an individual with impaired decision-making capacity.

¹² Douglass, A. *Mental Capacity: Updating New Zealand's Law and Practice* (Report for the New Zealand Law Foundation, Dunedin, July 2016) <http://www.lawfoundation.org.nz>

¹³ (Victoria Health, 2015)

¹⁴ (cited in Jeste et al 2018)

¹⁵ Jeste, Dilip V. et al, *Supported Decision Making in Serious Mental Illness*, Psychiatry. 2018 Spring; 81(1): 28-40.

¹⁶ Office of Disability Issues, MSD. Donald Beasley Institute literature review 2016 <https://www.odi.govt.nz/whats-happening/promoting-choice-and-control/>

¹⁷ RANZCP. 2018. *Code of Ethics*. https://www.ranzcp.org/files/about_us/code-of-ethics.aspx

This means taking into account and accommodating, as far as possible within the constraints of the Act, the person's will and preferences (either stated at the time or previously expressed). Central to its use is providing meaningful choices about treatment to patients.

1.3.2 Advance directives

Right 7(5) of the Code of Consumers' Rights states that 'Every consumer may use an advance directive in accordance with the common law.' An advance directive is a written or oral directive/instruction that enables a person to make choices about possible future health care treatment/s and becomes effective only when the person loses the capacity to make those choices themselves. Advance directives and advance care plans can be modified or revoked by the patient at any time, while they still have capacity.

As a best practice, all patients should be offered the opportunity to create an advance directive as part of recovery and relapse prevention planning. The process of discussing an advance directive creates the opportunity for clinicians to understand what is important to a patient, and what they do and do not want to happen in the event that a future episode of illness affects their decision-making capacity.

While clinicians are not obliged to act on an advance directive, the RANZCP Code of Ethics states that psychiatrists shall take into account any advance directive a patient has in place. This includes when someone is subject the Mental Health Act. There is some evidence that advance directives can reduce the need for compulsion.¹⁸

For further information about advance directives and advance care planning, see the Health Quality and Safety Commission's website, which links to a range of resources for patients and clinicians, including the Ministry of Health guidelines.¹⁹ The New Zealand Medical Association and the Health and Disability Commission also have information about advance directives on their websites^{20, 21}

1.3.3 Recovery planning

The Ministry of Health requires that clinicians regularly engage in recovery planning with every compulsory patient. The requirements of the Act augment recovery practice in relation to compulsory patients by promoting least restrictive care and directing including of family and whānau. These requirements also reflect good practice in relation to any consumer of mental health services.

Recovery planning in the framework of supported decision-making should take a person-centred approach in which the plan is a collaboration between the patient and

¹⁸ Southern DHB in collaboration with the University of Auckland has developed and trialled a new advance directive tool called Mental Health Advance Preferences statements (MAPs). <https://www.southernhealth.nz/getting-help-you-need/mental-health-and-addictions/mental-health-advance-preferences-statement>

¹⁹ Ministry of Health. 2011. Advance Care Planning: A guide for the New Zealand health care workforce. Wellington: Ministry of Health.

²⁰ <https://www.nzma.org.nz/patients-guide/advance-directive>.

²¹ <https://www.hdc.org.nz/your-rights/about-the-code/advance-directives-enduring-powers-of-attorney/>

clinician. Recovery plans need to be holistic, meaningful and place the patient at the centre of the plan. Ideally, the plan would be developed by the person themselves, with support from their clinician and their whānau or family (see section 5.3 below). Recovery plans help people to better manage their own condition and to produce positive mental health and wellbeing outcomes.

For further discussion on the concept of recovery see the RANZCP website: <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/recovery-and-the-psychiatrist>

Recovery plans should include discussion and planning for the patient's transitions between different parts of specialist services (eg inpatient and community) and also across services (eg specialist to primary care). There is evidence that improvements in the quality of people's mental health transitions can improve efficiencies in hospital resource utilisation, improve consumer satisfaction and rates of recovery, and increase in the person's resilience.²² However, a report by the Office of the Auditor General found significant deficiencies in the way that people transition through mental health and addiction services.²³

Transition planning aims to ensure that:

- service provision is matched as closely as possible to the needs of individuals and is delivered by the most appropriate services
- individuals and their families/whānau are the key decision-makers regarding the services they receive
- care is delivered across a dynamic continuum of specialist- and primary-healthcare-level services and decisions are based on the needs and wishes of individuals and their families/whānau (not service boundaries)

1.3.4 Right to support person

Right 8 of the Code of Rights states that 'Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.' In addition, the Mental Health Act section 9(2)(d) requires that a support person must be present when the purpose of assessment is explained to a proposed patient.

In a supported decision-making approach, people may call on one or more trusted support persons to help them to make a decision. Family, whānau and friends are a key part of a person's natural supports when it comes to decision-making and their engagement, where possible, is important.

²² HQSC literature review p.21 - <https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/Resources/Synergia-evidence-review-service-transitions.pdf>

²³ Controller and Auditor-General (New Zealand) (2017). Mental health: effectiveness of the planning to discharge people from hospital. Retrieved from Analysis and Policy Observatory Website: <https://apo.org.au/node/92766>

A support person who has previously been identified by the patient may help represent the person's intentions and preferences about their treatment and recovery to members of the treating team. This underlines the importance of asking about and documenting the patient's preferred support people.

2 Section 2: Interpretation

2.1 ‘Mental disorder’

The interpretation of ‘mental disorder’ in the Mental Health Act (section 2) governs entry into, and exit from, compulsory assessment and treatment for mental disorder.

Mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it –

- (a) poses a serious danger to the health or safety of that person or of others; or
- (b) seriously diminishes the capacity of that person to take care of himself or herself; –

and ***mentally disordered***, in relation to any such person, has a corresponding meaning.²⁴

The interpretation of ‘mental disorder’ has two ‘limbs’ to it. First, a person must be assessed as having an ‘abnormal state of mind (whether of a continuous or intermittent nature), characterised by delusions, disorders of mood, perception 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 health practitioner 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’ ‘if ‘having regard to all the circumstances considers it necessary to make a compulsory treatment order’ (section 27) ; and a person may remain under compulsory treatment for as long as they are ‘mentally disordered’. If they cease to meet the definition of ‘mental disorder they are entitled to be released (refer section 2.2, ‘fit to be released from compulsory status’).

The Mental Health Act applies only to those people with mental disorder who satisfy the two-part definition above. The first part 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 on the basis of their intellectual disability, substance use, personal, political or religious beliefs, or criminal or delinquent behaviour (section 4). People who are under the Mental Health Act may have an intellectual disability, an acquired brain injury or substance use issues, but they must also meet the two-part definition of mental disorder above.

The central criteria for initiating and continuing compulsory assessment and treatment is that a person is, or appears to be, *mentally disordered*. The Court of Appeal discussed the definition of ‘mental disorder’ at length in its decision in *Waitemata Health v Attorney-General*.²⁵ The following general points were made by the Court of Appeal in that case.

- The definition of ‘mental disorder’ is based on phenomena rather than diagnosis.²⁶ The Mental Health Act avoids reference to any particular mental or psychiatric illness. Instead, it provides a number of symptom clusters that might indicate an ‘abnormal state of mind’. These are ‘delusions, or disorders of mood or perception or volition or cognition’.
- The language of the ‘mental disorder’ definition seeks to avoid the debate over the difference between mental illness and behavioural disorders. A person with a severe personality disorder exhibiting any of the phenomena identified in the ‘mental disorder’ definition may well qualify for compulsory treatment under the Mental Health Act, despite not having a mental illness according to clinical definitions.

2.1.1 ‘Abnormal state of mind’

An ‘abnormal state of mind’ is determined wholly by the presence of one or more of the phenomena provided in the ‘mental disorder’ definition. Clinicians must not measure whether, taken as a whole, a person has an objectively abnormal state of mind compared with that of the average person, but whether any phenomena indicating an abnormal state of mind as described at 2.1.3 are present.

2.1.2 ‘Whether of a continuous or an intermittent nature’

The definition of ‘mental disorder’ specifically includes intermittent disorders, to allow for a fluctuating intensity of the phenomena characterising an abnormal state of mind. Remission and relapse of phenomena may occur during the course of a person’s recovery. In order to meet the definition of mental disorder, however, a causative link between abnormality of mind and the second limb of the definition must be established (Review Tribunal case 17/059).

²⁵ (2001) 21 FRNZ 216; [2001] NZFLR 1122.

²⁶ ‘Phenomena’ are abnormalities of specific areas of mental functioning (psychopathology) that may be observed. The presence of individual abnormal phenomena does not necessarily indicate a specific illness or diagnosis. ‘Diagnosis’ is an attempt to identify an illness, based not only on the presence of patterns of psychopathological abnormalities, but also on the basis of the cause (aetiology), time course (history) and outcome (prognosis) of the disorder. Diagnosis may be relevant to the definition in terms of assessing whether the disorder of mind is of a continuous or intermittent nature (for a fuller account refer to Dawson J. 1996. Psychopathology and Civil Commitment Criteria. *Medical Law Review*. 4: 62–83).

There is no requirement that the phenomena on which the mental disorder is based must necessarily be present at the time of examination, or at the time that the application is made. Compulsory treatment may be appropriate to continue or even initiate in cases where a person appears to currently be well if the person has previously demonstrated:

- repeated or prolonged episodes of illness
- severe consequences during phases of illness, such as severe violence to self or others
- early loss of insight during an episode of illness, with a pattern of failing to be able to take the necessary steps to halt the development of illness
- changeable insight into the nature of their mental illness that results in an inability to maintain a consistent decision to seek appropriate treatment.

However to avoid over application of the Act this should only occur if there is certainty that a person will become unwell again. Every effort should be made to take a supported decision-making approach to give the person the opportunity to determine how they would like to be cared for. (See section 1.3).

2.1.3 ‘Characterised by delusions, or by disorders of mood or perception or volition or cognition’

An abnormal state of mind must be characterised by delusions, or by disorders of mood or perception or volition or cognition.. These may be abnormal for the individual, compared to what is normal for the individual (as is the case in an acute illness, for example), or abnormal in terms of population norms.

Particular care must also be taken to ensure that the state of mind is ‘abnormal’ in terms of the individual’s cultural norms. These may include religious or spiritual belief systems. For example, in *Re MMG*,²⁷ the applicant believed in witchcraft and was a member of a community of witches, which included the applicant’s mother.

Several phenomena described in the mental disorder definition – delusions, disorders of mood and disorders of perception – are well-defined clinical concepts.

The Court of Appeal in *Waitemata Health* described in passing the phenomena in the definition of ‘mental disorder’ as words in ordinary use, although their application is heavily dependent upon the assessment of clinicians. This means that colloquial uses of those words are not sufficient to bring someone under the Act, but that phenomena are not strictly limited to their clinical definitions. For example, if a person is described as ‘deluded’ in a colloquial sense, it does not follow that the person has ‘delusions’ for the purposes of the Act. However, the Court suggested that a severe personality disorder

²⁷ *Re MMG* (NMHRT 568/98), 18 November 1998. The Mental Health Review Tribunal (MHRT) considered the applicant’s beliefs this factor, but the applicant was nevertheless considered to have fulfilled the criteria of the first limb of the mental disorder definition.

that led to an exceptionally disturbed view of the world could feasibly be taken to be a disorder of cognition or perception.²⁸

This interpretation has been applied in some subsequent cases²⁹, but questioned in others.³⁰ It should be noted that the ‘mental disorder’ definition was not directly at issue in the *Waitemata Health* case, the law in this area as unsettled. The Ministry therefore cautions against undue expansion of the psychiatric understanding of the disorders that can give rise to an abnormal state of mind.

The concepts of ‘disorder of volition’ and ‘disorder of cognition’ are not well-defined clinically and are open to interpretation, as explained below. The following explanations are intended to provide guidance.

Disorders of volition

‘Volition’ means the power to consciously choose or will, and includes the power to act on or abstain from acting on that choice or will.³¹

A disorder of volition may include:

- catatonic excitement or withdrawal
- depressive stupor
- passivity phenomena and command hallucinations
- amotivational syndrome in major psychosis.

These are examples of absent or changed volition that occur in the context of a major mental illness. Rare states such as conversion disorders, sleep walking and epileptic automatism may also be disorders of volition.

There are many other circumstances where volition may be seen as abnormal. These are within the areas of disorders of impulse control. Here, a person is aware of their actions and potential outcomes and has normal reality testing, but acts according to an impulse or desire for some reason. One of the difficulties here is the conflict between an irresistible impulse and an impulse not resisted. It is extremely difficult to judge clinically whether someone is able to resist an urge, but chooses not to, or is truly unable to resist. Whether these should be included as disorders of volition is, therefore, arguable. Examples of mental illnesses involving impulse control include:

- obsessive compulsive disorder

²⁸ *Waitemata Health* at [72].

²⁹ For example, in a later case concerning Mr H (*Re RCH* [2002] NZFLR 413), MHRT accepted the view that H’s severe personality disorder created overvalued ideas to the extent that it constituted a disorder of cognition. In *Re GTL* (MHRT 11/094, 7 December 2011) aspects of a person’s severe personality disorder were considered disorders of mood, volition and perception.

³⁰ See *Re RCH* (MHRT 12/039, 30 April 2012).

³¹ *Dorland’s Illustrated Medical Dictionary* (32nd ed 2012), *Mosby’s Dictionary of Medicine, Nursing and Health Professions* (3rd Australian and New Zealand ed 2018). NB – a new edition is due to be published in December 2019 – will check this before publishing guidelines.

- eating disorders
- impulsive states (for example, in borderline personality disorder or attention deficit disorder)
- psychosexual disorders (for example, paedophilia)
- substance use disorder
- kleptomania/pyromania
- pathological gambling.

It is the uncertainty of the group of illnesses listed above that gives rise to one of the largest potential abuses in the definition of mental disorder. Because the term ‘disorder of volition’ is not one that is generally used in psychiatry, its interpretation is difficult. Moreover, the *Diagnostic and Statistical Manual of Mental Disorders* refers to all the behaviours it describes as ‘disorders’, although many are not ‘mental disorders’ that could be subject to compulsory treatment under the Act. These factors result in confusion about how the legal term ‘disorder of volition’ should appropriately be applied to clinical situations. Many psychiatrists believe that obsessive compulsive states and eating disorders may be compulsorily treated if volitional control is reduced. This is still subject to consideration of the second limb of the definition of ‘mental disorder’.

There is a presumption that every person has the right to choose and the right to take responsibility for the outcomes of their choices. Compulsory intervention can only be justified when a person is affected by a condition that impairs or affects their ability to choose, with serious or dangerous consequences (ie., meets both limbs of the definition of mental disorder).

In general, conditions such as psychosexual disorders and anti-social personality disorder will not be considered an abnormal state of mind, unless particularly severe or complicated by another condition such as a disorder of mood, perception or cognition, delusions or intellectual disability. Personality disorders are addressed in more detail later in the section. Mullen (2013) explains that of the five specified characteristics of an abnormal state of mind, ‘volition’ is the one whose meaning is least clear. He further describes disturbed volition as not equating simply with disturbed behaviour where that behaviour is freely chosen. For example, paedophilic sexual assaults are not considered reasons for detention under the Act.

However, clinicians do see disturbances of volition in:

- a person with anorexia who will not eat;
- a person experiencing a psychotic episode who feels their will and actions are under alien control;
- the negative symptoms of a person with schizophrenia that leaves them disabled by a lack of motivation; the range of involuntary movements associated more with neurology than psychiatry;
- the impairments due to intoxication;
- catatonia.

Disturbances of volition might also be invoked in relation to those disturbances of behaviour, such as self-harm, that is often associated with a personality disorder. However, this involves inferring whether the individual is genuinely choosing their behaviours.³²

Disorders of cognition

‘Cognition’ includes processes of perceiving, knowing, recalling, thinking, learning, evaluating and understanding, and the processes of obtaining, organising and utilising sensory and perceptual information, remembering past experiences, and making plans or strategies.³³

‘Cognition’ can also refer to a thought. The potential difficulty when using the term ‘disorder of cognition’ is ascertaining cognition as a process or cognition as a thought. It is inappropriate to define ‘cognition’ as a thought, rather than a process, to include people with deviant but non-delusional thoughts in the scope of the Mental Health Act. Should cognition be seen as the process of thinking, perceiving and recalling, then the use of this concept should not spread excessively beyond that intended by Parliament.

Disorders of cognition include:

- slowing of cognition in depressive states
- increased rate of cognition in manic states
- disorganisation or disruption of thought process in psychotic states
- cognitive changes in dementia and other acquired organic mental disorders.

A disorder of cognition can be seen to encompass thought disorders (as often noted during a psychotic episode), namely disorganised or illogical thought processes of a severe degree, or absence of thought. As the terminology is different (‘cognition’ versus ‘thought’), some clinicians have been uncertain as to whether a thought disorder is included in a disorder of cognition. In the Ministry’s view, it is. Thought disorders may be the only mental state abnormality in some manifestations of psychosis. It may also cover:

- obsessional rumination in obsessive compulsive disorder
- disordered self-perception such as in eating disorders
- anxiety disorders with recurrent ruminations.

³² Mullen, R 2013. Chapter 12. In: J Dawson, K Gledhill (eds). *New Zealand’s Mental Health Act in Practice*. Victoria University Press, Wellington

³³ *Dorland’s Illustrated Medical Dictionary* (32nd ed 2012), *Mosby’s Dictionary of Medicine, Nursing and Health Professions* (3rd Australian and New Zealand ed 2018). NB – a new edition is due to be published in December 2019 – will check this before publishing guidelines.

It is rarely appropriate to compulsorily treat conditions characterised only by recurrent dangerous thoughts such as inappropriate sexual desires or violent fantasies. To be compulsorily treated, such conditions should be characterised by a lack of control over acting on such thoughts of such severity as to constitute a disorder of *volition*. Without such a volitional disorder, such persons will rarely present a sufficient danger to the safety of others to satisfy the definition of mental disorder.

Intellect is clearly a component of cognition. Intellectual disability can be seen as a disorder of cognition for the purpose of section 2 of the Mental Health Act. However, section 4(e) of the Mental Health Act qualifies this by stating that Parts I and II of the Mental Health Act shall not be invoked in respect of any person by reason only of intellectual disability.

Personality disorder

Personality disorder is a contentious area for clinicians, academics and the law. Within psychiatry there is no consensus that personality disorders should be subject to compulsory treatment, the problems faced by people with personality disorders are often considered at the margins of what can usefully be considered a mental disorder.³⁴

Mullen (2013) explains that when a person with a personality disorder presents as distressed or threatening, it is not difficult to conclude that they are at greatly increased risk of serious self-harm or harm to others; satisfying the second limb of the test for 'mental disorder'. He adds that it is also usually clear whether they are greatly impaired in their ability to self-care. What is harder, and where clinicians often disagree, is whether such risk or poor self-care is beyond the patient's capacity to manage, and whether compulsory treatment is likely to assist.

Individuals with personality disorders are neither specifically included in nor excluded from the provisions of the Mental Health Act, because the Mental Health Act is couched in terms of clinical phenomena rather than in terms of diagnosis. Individuals who display the phenomena covered by the definition of mental disorder (abnormal state of mind), which will include some individuals with certain types of personality disorder, may be brought within the scope of the Mental Health Act when necessary.

Head injury

A person may be compulsorily treated due to a mental disorder arising from a head injury. As mentioned above at 1.1, the definition of mental disorder under the Act is deliberately stated in terms of phenomena rather than diagnoses. The Act requires an abnormal state of mind characterised by one or more phenomena, including 'disorder of cognition'. This applies irrespective of whether the disorder results from a diagnosis of mental illness (in the narrow sense) or any other cause, such as traumatic brain injury, hypoxia, toxicity or dementia.

Section 4 of the Act contains the only reference to diagnosis. This specifically excludes certain conditions (such as intellectual disability) as a sole reason for invoking

³⁴ Mullen, R 2013. Chapter 12. In: J Dawson, K Gledhill (eds). *New Zealand's Mental Health Act in Practice*. Victoria University Press, Wellington

compulsory assessment procedures. There is no clause in the Act that excludes head injury as the basis of its application.

2.1.4 ‘Of such a degree that’

The first limb of the ‘mental disorder’ definition must give rise to the second limb. A person might both have an abnormal state of mind, and pose a significant danger to self or others, but will not be mentally disordered unless the abnormal state of mind actually causes the person’s dangerousness or diminished capacity for self-care.

2.1.5 ‘Poses a serious danger to the health or safety of that person or of others’

The determination of serious danger to self and others has been discussed in many judicial and Mental Health Review Tribunal (MHRT) cases. For example, in 11/040 the MHRT said the level of dangerousness can be assessed having regard to the following considerations:

- (i) What is the magnitude or gravity of the behaviour concerned?
- (ii) What is the likelihood of the behaviour occurring?
- (iii) What is the proximity of imminence of the behaviour, in other words, how soon or quickly might it occur?
- (iv) What is the frequency of the behaviour, that is to say, how often might it occur?³⁵

In 11/040, the MHRT also identified some further useful questions which might be posed when assessing level of dangerousness:

- the degree of causal connection between relapse and dangerousness;
- the expected time lapse between release from compulsory status and cessation of treatment;
- the estimated time lapse between non-compliance with treatment and relapse;
- whether interventions by clinicians or friends or others can prevent or lessen a relapse which is in its early stages; and
- the ability of clinicians to re-initiate the compulsory assessment and treatment provisions of the Act.

These criteria need not all be met to a high level for a serious danger to be posed. The nature and magnitude of the potential harm posed by a person may be low, but the frequency at which this harm is exhibited may be high enough to amount to serious danger if, for example, the person is engaging in repetitive harmful behaviour as a result of an abnormal state of mind. Likewise, a person may have committed one or two violent acts as the result of an abnormal state of mind but remain a serious danger to others due to this potential harm. The following factors may help determine whether ‘serious danger’ is posed:

- situational circumstances and conditions that affect the likelihood of harm occurring

³⁵ See *W NZMHRT 11/126*, 2 March 2012.

- balancing the potential for harm against the nature of the proposed intervention.

Serious danger to the safety of others will normally involve the prospect of violence by the person towards others but includes other acts likely to increase the risk of injury to others, for example, loosening the bolts on a car's wheels.³⁶

Serious danger to the safety of the person in question may arise if a person's argumentative or confrontational demeanour, which is a result of an abnormal state of mind, makes the person likely to be the victim of violence from others.³⁷ It may also arise if a particularly vulnerable person has a history of being sexually exploited when affected by an abnormal state of mind.³⁸ There may also be a serious danger to the safety of a person if an abnormal state of mind leads to suicidal ideation.

When considering a serious danger to the health of others, both physical and psychological health should be considered.³⁹ A person with an erotomaniac fixation (where a person believes someone else is in love with them, despite contrary evidence) might constitute a serious danger to the mental health of others. In *Re IC*,⁴⁰ there was evidence that a person's obsessional attachment and stalking behaviour had caused great anxiety and fear to his victim and her family, but there had been no physical threats. The Review Tribunal held that 'there is clear and unequivocal evidence to show that [the] behaviour poses and continues to pose a serious danger to the psychological health of the victim and her family'. A 'mentally disordered' parent with custody of their child may present a serious danger to the physical or mental health of that child if not subject to compulsory treatment and less restrictive options are not available.⁴¹

Serious danger to the health of the person in question may occur if the person has a chronic illness such as diabetes and is unable to manage their condition due to an abnormal state of mind. The clinician should be mindful of whether a person's experiences of repeated acute bouts of mental illness may contribute to the overall deterioration of that person's condition. However, if a person does not have the capacity to make decisions related to their physical health, compulsory treatment under the Mental Health Act should not be initiated for the purpose of treating physical health problems. The appropriate course of action is to seek a treatment order or an order appointing a welfare guardian under the Protection of Personal and Property Rights Act 1988.

To assist balancing the potential for harm against the need for compulsory treatment, clinicians may want to examine the protective factors and strengths posed by the person in question. That is, what situational circumstances and conditions are going to protect the person and keep them safe.

³⁶ As in *Re MMG* NMHRT 568/98, 18 November 1998.

³⁷ As considered in *Re TRK* MHRT 08/114, 19 August 2008.

³⁸ *Re JFW* MHRT 11/027, 21 April 2011.

³⁹ See *Re RWD* [1995] NZFLR 28.

⁴⁰ [1996] NZFLR 562.

⁴¹ *Re TRK*.

2.1.6 ‘Seriously diminishes the capacity of that person to take care of himself or herself’

Self-care is not limited to the basic necessities of survival (activities of daily living such as food, shelter, hygiene and medication) but includes ‘the multiplicity of other needs such as achieving financial security, maintaining proper social relationships, maintaining stable accommodation and seeking out ... the assistance of others ... concerning health and lifestyle’.⁴² Self-care has been said to embrace all of ‘the higher complexities of modern living’⁴³ and the ‘ability to cope adequately in the community’.⁴⁴

Self-care is not simply that which is in the ‘best interests’ of a person, if they behave in some way that makes them a nuisance to others.⁴⁵ Nor does it include provision for ‘the capacity to find happiness in life and fulfil potential’;⁴⁶ these are considered to be private and individual matters independent of any mental disorder.

Self-care can also be regarded as those essential functions that can be ‘reasonably readily provided or addressed by others’.⁴⁷ The degree of outside care available to a person is a relevant factor in the mental disorder test. If the support of whānau or friends is present to adequately fill the functional gap created by diminished capacity, or to lessen the risks posed to self or others so that they are no longer ‘serious’, a person who is otherwise mentally disordered may be released from compulsory care.⁴⁸

The test of diminished capacity is neither wholly subjective nor wholly objective. A subjective test of diminished capacity may unfairly target people of a specific demographic. Although a person’s capacity for self-care may be seriously diminished by a mental illness, they may still cope adequately in the community. An objective test, on the other hand, may target persons with a below-average capacity independent of any abnormal state of mind, such as those with an intellectual or physical disability, or frailty due to age. In *Re C*,⁴⁹ the court described a mixed objective/subjective test of ‘what an ordinary citizen would find acceptable as a minimum standard of effective self-care for a person of the patient’s circumstances and background’.

⁴² *Decision 324/95* NMHRT 324/95, 14 June 1995.

⁴³ *Re AVHM* MHRT 08/110, 25 August 2008.

⁴⁴ *Decision 324/95*.

⁴⁵ *Re SFC* MHRT 02/032, 4 November 2002

⁴⁶ *Re AVHM*.

⁴⁷ *Re AVHM*.

⁴⁸ *Re TRT* MHRT 09/078, 14 August 2009.

⁴⁹ DC Auckland, CAT 132/99, 28 August 2000, Thorburn DCJ.

Capacity for self-care is ‘unique to the individual having regard to both intrinsic and extrinsic considerations, that is to say, the qualities and characteristics of the individual, together with the features of their environment’.⁵⁰ This approach recognises a person’s unique skills and talents. A certain minimum capacity has been generally considered sufficient in all but the most exceptional cases, as there is a ‘broad commonality’ between the minimum capacities of most members of the community.⁵¹

It is appropriate to primarily enquire as to whether a person meets an objective base-level of capacity for self-care. However, diminished capacity has sometimes been established when a person has feasible goals requiring a high level of functioning, such as running a business,⁵² working as a doctor⁵³ or attending university.⁵⁴

2.2 ‘Fit to be released from compulsory status’

The Act defines ‘fit to be released from compulsory status’ to mean ‘no longer mentally disordered and fit to be released from the requirement of assessment or treatment’ under the Act.

The Court of Appeal in *Waitemata Health* held that the interpretation of this provision was that fitness to be released automatically follows when a person is no longer mentally disordered. If a person remains mentally disordered, it follows that they are therefore not fit to be released.

As described above in section 2.1, the term ‘mental disorder’ in the Mental Health Act has two limbs. And for someone to remain on the Act, they must meet both criteria. That includes the abnormal state of mind, characterised by delusion or by disorders of mood or perception or volition or cognition of such a degree that it 1) poses a serious danger to the health and safety of that person or of others; or 2) seriously diminishes the capacity of that person to take care of themselves.

The Review Tribunal in case 17/059, writes that:

“...the mental disorder definition requires a causative link between abnormality of mind and the second limb.....When it is not necessary to maintain a compulsory treatment order, due to good adherence to medication, for example, the severity criteria in the second limb of the mental disorder definition may no longer be met, even if the person’s abnormal state of mind is still present under the first limb. In this way, the person will, therefore, be fit to be released from compulsory status because they no longer meet the definition of mental disorder (ie., there is no longer a causative link between abnormality and risk)”⁵⁵.

⁵⁰ *Re Y* MHRT 11/139, 18 January 2012.

⁵¹ *Re AVHM*.

⁵² *Re TJJ* MHRT 07/037, 27 April 2007.

⁵³ *Re AEAA* MHRT 08/012, 7 July 2008.

⁵⁴ *Re AVHM*.

⁵⁵ MHRT 17/059, 15 June 2017, NZLII <http://www.nzlii.org/nz/cases/NZMHRT/2017/15.html>

Even though the issue of “necessity” is not a required legal test in determining whether a person is ‘fit to be released’ from the Act (as it is for the District Court when making a compulsory treatment order), it can be taken into account. Additionally, a clinician should consider what compulsory treatment is intending to achieve and whether there are any other services available that can assist in maintaining a patient’s mental health without the need for compulsory treatment (less restrictive alternatives).

It is important to consider information/evidence on the factors that have contributed to a person’s recovery, management of their mental disorder, and ability to self-care.. For example, in the case of FL where the applicant was released from compulsory status, positive aspects of the applicant’s life were identified as contributing to the person’s recovery such that they no longer met the definition of ‘mental disorder’, such as stable employment and accommodation, present support systems such as family and a positive intimate relationship, as well as ceasing use of substances.⁵⁶ The MHRT also considered the applicant’s view of their mental disorder and progression.

Upon turning to the test for mental disorder, the MHRT ruled that, in this case, the severity of the patient’s mental disorder and the presence of risk was not at a sufficient level to require compulsory treatment. The MHRT encouraged the mental health services to maintain contact with the applicant and their family in light of their risk assessment.

2.3 ‘Person in charge’

The Act defines the person in charge of a hospital or a service to be the chief executive officer.

The authority to admit and detain a patient or proposed patient to a hospital is granted to the person in charge of the hospital under section 113.

Under section 99B the person in charge of a hospital may delegate their powers under the Act to another person who is suitably qualified, often the Director of Area Mental Health Services (DAMHS). The delegation must be in writing, and any revocation of the delegation must also be in writing. It is recommended that the power to admit or detain a patient or proposed patient only be delegated to a person who is suitably qualified and has a relevant clinical background. For example, members of a psychiatric crisis team, and/or designated staff in an acute psychiatric unit. To avoid any risk of unlawful detention, this authority should be delegated to a person normally present at the hospital.

2.4 ‘Principal caregiver’

The Act defines the ‘principal caregiver’ to mean ‘the friend of the patient or the member of the patient’s family group or whānau who is most evidently and directly concerned with the oversight of the patient’s care and welfare’. In line with a supported decision-making approach (see section 1.3), clinicians should contact the principal caregiver where practicable e.g. section 7A family and whānau consultations (see

⁵⁶ REF FL 18/087, 24 July 2018 – sent to Ministry of Health 5 August 2018 (not published)

section 5). It is important to note that more than one principal caregiver may be appointed.⁵⁷

The fact that the patient does not give the name of the principal caregiver, or does not authorise, or even forbids, the principal caregiver being contacted, does not affect the statutory duty to send the principal caregiver a copy of the certificate of preliminary (section 10(4)(a)(iv)), further (section 12(5)(d)) and final (section 14A(2)(c)) assessment, and a copy of a certificate of clinical review that states that the patient is (or is not) fit to be released from compulsory status (section 76(7)(b)(iii)).

The Privacy Act 1993 does not affect the clear statutory duty of notification in these circumstances,⁵⁸ nor does the Health Information Privacy Code or the Code of Rights.

If the patient is competent to make a decision about who is the principal caregiver, their advice as to who the principal caregiver is should be accepted. This information may also have been given in an advance directive. Even if a patient is not competent to choose a principal caregiver, their preferences should be given significant weight. For many patients, there is no dispute as to who the 'principal caregiver' is.

If there is doubt or disagreement, the viewpoints that need to be considered are those of:

- the patient
- spouse or partners
- the family/whānau
- friends of the patient
- an enduring power of attorney
- health professionals in the service
- other parties concerned with the care of the patient, for example, prison staff.

In cases of doubt or dispute, the DAMHS should take responsibility for the decision about:

- whether the patient is competent to advise who the principal caregiver is
- who the 'principal caregiver' is for the purposes of the Act.

The DAMHS will be advised by the responsible clinician or appropriate duly authorised officer (DAO) involved. In cases of dispute, the DAMHS should consult with other knowledgeable parties, for example a social worker. In cases of dispute with patients who identify as Māori, the DAMHS should also consult with Māori health workers and cultural support staff.

Section 7A of the Act also creates an obligation to consult with the patient or proposed patient's family or whānau (see section 5.2 below).

⁵⁷ *Re HM* [1999] NZFLR 858.

⁵⁸ See *Re EW*, 24/1/96, Judge McElrea, DC Auckland.

2.5 ‘Registered nurse practising in mental health’

The Act defines a 'registered nurse practising in mental health' as 'a health practitioner who is, or is deemed to be, registered with the Nursing Council of New Zealand by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice includes the assessment of a person's mental capacity; and who holds a current practising certificate.'

The inclusion of capacity in the definition of “registered nurse” is only a guide to the interpretation of “registered nurse”, not a guide to interpretation of the term “mental disorder”. Nurses acting as health practitioners under section 8B (1) should therefore assess the proposed patient in terms of the section 2 criteria for “mental disorder”.

As health practitioners, nurses are responsible for practising both within their scope of practice as defined by the Nursing Council of New Zealand, and within their level of competence.

A ‘registered nurse practising in mental health’ for these purposes could be a registered nurse who works in a mental health context, or who has a significant mental health component to their work and practise experience. The DAMHS, in conjunction with Directors of Mental Health Nursing, should assess which registered nurses within their regions are suitably competent for this role.

Te Ao Māramatanga (2018), suggests that nurses who may be asked to issue section 8B certificates seek clarification of this function from their DAMHS.

The DAHMS may also consider providing registered nurses with specific training to assist registered nurses working in mental health to complete a section 8B certificate.

More information can be found in the Te Ao Māramatanga (2018) New Zealand College of Mental Health Nurses, *Practice note: Nursing practice and section 8b – Mental Health (Compulsory Assessment and Treatment) Act 1992*.

3 Section 4: Exclusion criteria

Section 4 of the Act prohibits compulsory assessment and treatment by reason only of a person's political, religious or cultural beliefs, their sexual preference, criminal or delinquent behaviour, substance abuse [use] or intellectual disability. However, section 4 does not prohibit assessment and treatment of patients who have a mental disorder but might otherwise fit within one of the section 4 categories. In *Re H*,⁵⁹ Judge Inglis summarised the position.

Once [the Court has found that the patient is mentally disordered within the definition], it is irrelevant for the purposes of parts I and II that the state of the mental disorder exists because the patient is also intellectually disabled. There is no logic in terms of the scheme and purpose of the Act in preventing a person, [who] is mentally disordered to a degree where a compulsory treatment order is required, from being compulsorily treated merely because the consequences of his mental disorder are heightened by his intellectual disability. The true purpose of section 4(e) is to prevent it being too readily assumed from a state of intellectual disability that there must also be a state of mental disorder *as that term is defined by the statute*. I have italicised the last words to make it clear while intellectual disability may, in its nature, involve some degree of mental disorder in a general sense, it may not involve mental disorder in the specialised statutory sense.

The exclusion factors in section 4 indicate some of the limits of the imposition of compulsory treatment. It is unacceptable for people to be detained in a psychiatric hospital for their political, religious and cultural beliefs, or sexual preference (sections 4(a) and 4(b)).

Compulsory treatment should be confined to those with a mental disorder, not a disagreement with the State. This is the rationale for section 4(c) of the Act, which excludes criminal or delinquent behaviour. Conflicts of these types between the individual and society are best reserved for the criminal justice system. Psychiatry's ethical position in the treatment of people experiencing mental illness is undermined if it becomes an agent of State control for groups of people who society may find irksome.

Section 4(d) of the Act, which excludes 'substance abuse' as a sole reason for compulsory assessment and treatment, is discussed below at 2.1. Section 4(e) of the Act excludes the application of the Act on the grounds of intellectual disability alone, and is discussed below at 2.2.

Note: The term substance abuse is used within this Act to denote individuals that have problematic use of substances (drugs or alcohol). The terminology 'substance abuse'

⁵⁹ *Re H [Mental Health]* (1993) 10 FRNZ 422.

does not align with modern practice, therefore, 'substance use' is used in these Guidelines unless directly quoting legislation.

Substance use and intellectual disability may contribute to a person's abnormal state of mind, so long as substance use or intellectual disability is not the sole cause of a person's abnormal state of mind. However, an assessing clinician or judge may consider the risks that arise as a result of any aspect of that person's abnormal state of mind, including a person's compulsive substance use or intellectual disability, when determining whether a person is mentally disordered (see section 2.1.3 above).

3.1 Substance use

Section 4(d) of the Act specifically excludes substance use (drugs or alcohol) as a sole basis for the application of procedures for compulsory assessment and treatment under the Act. But the presence of substance use does not preclude the use of the Act if the criteria for 'mental disorder' are otherwise met.

The following are examples of the types of situations in which mental disorder may arise in the context of substance use.

- When an intoxicated individual displays suicidal behaviour, or threatens suicide or self-harm, it may be appropriate to utilise the Act. It may be reasonable to form the belief that someone who is threatening suicide or acting in a suicidal manner may be mentally disordered, no matter how intoxicated they are.
- The acute effects of intoxication may present as a mental disorder, for example the effects of hallucinogenic drugs may mimic psychotic symptoms. Persons in such a state will often meet the lower threshold for assessment and treatment under Part 1 of the Act; that is, there will be reasonable grounds to believe that they are mentally disordered until the cause of their symptoms becomes apparent (see 5.1 below).
- Mental disorder may arise as the consequence of long-term substance use, for example the cognitive impairment of a Korsakoff's psychosis. If there is a mental disorder, irrespective of its underlying causation, the Mental Health Act may apply. Use of the SACAT Act may be more appropriate in these circumstances, however, the Mental Health Act should be prioritised over SACAT if the person meets the definition of 'mental disorder under the Mental Health Act.
- Individuals who have a 'dual-diagnosis' or 'co-morbidity' of a mental disorder and a substance use disorder will require additional support and consideration.

The terms of a community treatment order or leave from an inpatient order, can specify whether abstinence from substances should be supported. The individual should be encouraged and supported to abstain from substances to minimise the harms associated with its use.

The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the SACAT Act) allows for compulsory treatment of people who have a severe substance addiction if their capacity to make decisions about treatment for that addiction is severely impaired. Treatment must be deemed to be necessary and appropriate treatment must be available. The intention is to protect the person from serious harm,

stabilise their health, protect and enhance their mana and dignity, and restore their capacity to make informed decisions about further treatment and substance use.

‘Severe substance addiction’ is defined in the SACAT Act as an addiction with such severity that it poses a serious danger to the health or safety of the person and seriously diminishes the person’s ability to care for himself or herself.

The definition of ‘severe substance addiction’ focuses on a degree of addiction that is clearly beyond problematic substance use and mild to moderate substance use disorders. The features of severe substance addiction such as neuro-adaptation to the substance, craving for the substance and unsuccessful efforts to control the use of the substance can be assessed against internationally recognised criteria and are measurable over time.

The definition of severe substance addiction within the Act does not include posing a risk of ‘harm to others’. While the actions of persons with severe substance addiction can cause harm to others, the most significant harm is to themselves.

The second criteria for compulsory treatment under the SACAT Act relates to a person demonstrating severely impaired capacity to make informed decisions about treatment for that addiction. This is defined as an inability to:

- understand the information relevant to the decisions,
- retain that information,
- use or weigh that information as part of the process of making the decisions, and
- communicate the decisions.

While co-morbid mental health and substance use issues are not uncommon, the intent of the SACAT Act was solely to protect and stabilise those with the most severe substance addiction. The SACAT Act is not intended to treat those with ‘mental disorder’, for which the Mental Health Act can provide better support and treatment.

If a person presents with severe substance addiction as well as psychosis or symptoms indicative of a potential mental health disorder, the treating team should consider whether the person better meets the definition of ‘mental disorder’ under the Mental Health Act. A person cannot be under the Mental Health Act and the SACAT Act at the same time.

Treatment of substance use (including addiction) should never be the primary reason for compulsory treatment under the Mental Health Act. However, if a patient or proposed patient under the Mental Health Act presents with substance use related issues, mental health services should engage with local addiction services to support the person to address their substance use.

3.2 Intellectual disability

Section 4(e) of the Act specifically excludes intellectual disability as a sole basis for the application of procedures for compulsory assessment and treatment under the Act. But the presence of intellectual disability does not preclude the use of the Act if the criteria for ‘mental disorder’ are otherwise met.

Examples of situations where intellectual disability and mental disorder may concurrently occur include:

- intellectually disabled persons who present a serious danger to the safety of others due to a co-morbid psychosis, and who may be treated under either the Mental Health Act or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- persons with Down Syndrome who also develop a degenerative mental illness such as dementia.

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 provides a legislative basis for the compulsory care of intellectually disabled persons who have been charged with, or convicted of, an offence. When a person with an intellectual disability is also experiencing and being treated for a mental disorder, it can be beneficial for mental health clinicians to involve clinicians who specialise in the care of intellectually disabled people.

The Mental Health Act is not suitable for providing care for people incapacitated solely by an intellectual disability. The Protection of Personal and Property Rights Act 1988 provides a legislative basis for care decisions to be made on behalf of an incapacitated person by a welfare guardian appointed by a court for that purpose, or by an order of a court.

4 Sections 5 and 6: Respect for cultural and personal rights

Sections 5 and 6 require powers to be exercised with respect for a person’s culture, language and beliefs. The use of the word ‘person’ in sections 5 and 6 indicates that section 5 applies to all people before they become proposed patients, and once they become proposed patients and patients.

The requirements of sections 5 and 6 of the Act mean that staff need to know how to access the services of an interpreter and appropriate cultural advisors, often at short notice. Mental health services should balance their responsibilities under sections 5 and 6 of the Act with the need to ensure that the overall goal of proper care for a patient or proposed patient is not unnecessarily hindered.

4.1 Cultural identity

Section 5 requires the powers of the Act “to be exercised with proper respect for cultural identity and personal beliefs”, including:

“with proper recognition of the importance and significance to the person of the person’s ties with his or her family, whanau, hapu, iwi, and family group (5(2)(a)), and

with proper recognition of the contribution those ties make to the person’s wellbeing (5(2)(b)), and

with proper respect for the person’s cultural and ethnic identity, language, and religious or ethical beliefs (5(2) (c)).”

There is strong evidence to support the need for proper respect for cultural identity and personal beliefs of people who enter mental health services. Māori are significantly over-represented in populations treated under the Act.⁶⁰ It is likely that several factors contribute to this, including significant disparities between Māori and non-Māori in rates of serious mental illness, co-existing conditions and complex and late presentations.⁶¹

⁶⁰ Ministry of Health 2019. Office of the Director of Mental Health Annual Report 2017.

⁶¹ (Elder, H., Tapsell, R. 2013. Chapter 14. In: J Dawson, K Gledhill (eds). *New Zealand’s Mental Health Act in Practice*. Victoria University Press, Wellington).

Note that section 65 of the Act affirms that ‘every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5’. This requirement is reinforced by Right 1(3) of the Code of Health and Disability Services Consumers’ Rights (the Code of Rights), and section 15 of NZBORA states that every person has the right to manifest that person’s religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private. As a basic patient right the entitlement to be dealt with in a culturally appropriate manner becomes enforceable through the complaints procedures set out in section 75. Further, section 65 of the Act, and therefore section 5 of the Act, could be subject to a Code of Rights investigation by the Health and Disability Commissioner.

Section 66 of the Act affirms a patient’s right to receive medical care and other health care which is appropriate to their condition. Substantive treatment which takes proper account of a patient’s cultural identity and personal beliefs is an inherent component of the right of a patient to medical treatment and health care appropriate to their condition, contained in section 66 of the Act.

4.1.1 Culturally responsive care

It is important that services demonstrate culturally responsive care. Culturally responsive care is concerned with the attitudes of staff towards patients. It is shown when:

- healthcare staff show respect for a patient’s beliefs and values and
- healthcare workers are aware that the imposition of their own beliefs and values may disadvantage the patient. Showing respect can help direct a patient towards better health.

Services must work with the patient/potential patient and their family, whanau and principal caregiver to ensure that the care provided is responsive to the needs of people of any culture. Services should monitor and record whether or not a cultural assessment has been made and why. Moreover, if a cultural assessment has not taken place, arrangements should be made to do so. Services should have arrangements in place to engage people in a cultural assessment process or refer people for cultural assessment by e.g. kaupapa Māori, Pacific people’s health services or other culturally relevant services.

Given that Māori and Pacific peoples are significantly overrepresented under the Mental Health Act, services are particularly expected to be capable of delivering care that is responsive to and respectful of the cultures of these populations.

Relevant knowledge about cultural and personal beliefs is required to help inform a patient’s substantial diagnosis, care and treatment, and to help ensure that the process of the provision of care and treatment is appropriate.

Te Whare Tapa Wha

A key model for understanding hauora Māori is the concept of ‘Te Whare Tapa Whā’ – the four cornerstones of Māori health.⁶² The model uses the concept of a whare (house)

⁶² Durie, Mason. ‘Māori Health Models—Te Whare Tapa Whā’. <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha>

to describe four key dimensions of Māori well-being. All four walls are needed, and must be in balance, for the house to be strong. Should one of the four dimensions be missing or in some way damaged, a person, or a collective may become ‘unbalanced’ and subsequently unwell.

The dimensions described in Te Whare Tapa Whā are:

- te taha wairua (the spiritual dimension)
- te taha whānau (family)
- te taha hinengaro (mind)
- te taha tinana (physical)

The SACAT Act explicitly requires the enhancement of an individual’s mana. To support practitioners delivering services under the SACAT Act, Te Rau Ora (originally Te Rau Matatini) has developed a guide for mana enhancing and mana protecting practice, Manaaki.⁶³ While this guide was developed for service delivery under the SACAT Act, there is useful information and guidance related to the concept of mana, and mana enhancing practice that can be applied to services delivered under the Mental Health Act.

While the Mental Health Act does not have an explicit requirement for services to enhance a person’s mana, the obligation to respect cultural identity and personal beliefs under section 5, and the right to this respect under section 65 along with the application of the principles of Te Tiriti o Waitangi may necessitate providers to deliver care in such a manner that an individual’s mana is considered and ultimately enhanced.

Pacific models of care

In feedback to the Government Inquiry into Mental Health and Addiction, Pacific mental health and addiction providers described current service delivery under the Act as not considering, nor culturally responsive to, specific Pacific world views⁶⁴. Similar to the Te Whare Tapa Whā model of care, one key model for engaging with Pacific peoples is the Fonofale model of health.⁶⁵ Under this the model, the roof of the fale represents cultural values and beliefs that are the shelter for life. The foundation of the fale represents family which is the foundation for all Pacific island cultures. The four pou, or posts, go from the foundation to support the roof. These four posts each represent a different dimension that connects family and culture together:

- spiritual
- physical
- mental
- other (variables that can directly or indirectly affect health)

⁶³ Huriwai, T & Baker, M (2016). Manaaki: Mana enhancing and Mana protecting practice. Wellington: Te Rau Matatini. Available at: <https://terauora.com/wp-content/uploads/2019/05/Manaaki-Mana-Enhancing-and-Mana-Protecting.pdf>

⁶⁴ Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.

⁶⁵ <http://healthhb.co.nz/wp-content/uploads/2014/09/Fonofale-model.pdf>

Another key Pacific health model that can be considered and applied in the mental health context is the Papao model of recovery.⁶⁶ This model uses the analogy of the papao, an outrigger canoe, and emphasises the concept that the mental health treatment process is a journey towards recovery and strength within a Pacific paradigm.

4.1.2. Recognition of family and whānau

Section 5(2)(a) explicitly requires that family/whānau relationships be recognised if they are beneficial to a person’s wellbeing. Family/whānau should be encouraged to provide information about the person, in terms of that individual’s history, and feedback on any changes noticed when the person is on leave or in the company of family/whānau members. It is important to involve family/whānau throughout the course of treatment.

The relationship between the person and their family/whānau may change over time. A person who refuses contact with family/whānau may change their mind and the wishes of family/whānau should be considered whenever possible (see section 7A of the Act).

Note that the Privacy Act does not preclude information from being provided by family/whānau members and does not prevent family/whānau members and other caregivers from being provided with information about the person⁶⁷ for example if:

- disclosure was one of the purposes for which the information was collected⁶⁸
- there is a serious and imminent threat of self-harm by the person⁶⁹
- the person is being discharged into the care of family/whānau.

Clinicians should assist a person’s family/whānau to understand aspects of the person’s illness if they are expected to be a part of their support group. For example, clinicians should provide information about the person’s medication needs and any kinds of behaviour they should be concerned about.

4.1.3 Section 5(2)(c) ‘proper respect for the person’s cultural and ethnic identity, language, and religious or ethical beliefs’

The Act requires that those who administer the Act must do so with proper respect for the person’s cultural and ethnic identity, language, and religious or ethical beliefs at any point that the Act is administered. Services must ensure that the person’s identities are not compromised, and that they receive appropriate assessment and treatment that is respectful of their identities (including ethnicity and gender), beliefs, and language.

⁶⁶ <https://www.tepou.co.nz/uploads/files/resource-assets/the-papao-model-a-pacific-recovery-and-strength-concept-in-mental-health.pdf>

⁶⁷ See Ministry of Health. 1996, *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services (The Mason Report)*. Wellington: Ministry of Health. Chapter 4.

⁶⁸ See section 6, Principle 11(a) Privacy Act 1993.

⁶⁹ See section 6, Principle 11(f)(ii) Privacy Act 1993.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed a position statement to provide guidance on how consideration of religion and/or spirituality can improve outcomes for people living with mental illness⁷⁰. The guidance is relevant to clinicians working with patients, proposed patients and their families and whānau under the Mental Health Act.

Although the Act does not explicitly extend this recognition to a person's gender and sexual orientation, the Ministry of Health is committed to improving health care for our rainbow⁷¹ communities should also be mindful and respectful of this. It is important that health services meet the needs of all New Zealanders, with inclusiveness, mana and dignity for all. This includes referring to a person by their preferred name and pronoun, and asking open-ended questions to avoid assuming the 'categories' a person may identify with.⁷²

It is also important to note that there are many different terms that a member of the rainbow community might identify with. For example, transgender and gender diverse are umbrella terms that cover a wide variety of gender identities for people whose gender varies from their assigned sex at birth. Other words people might use to describe their gender identity, including Māori and Pacific terms, include: aikāne, akava'ine, fa'afafine, faafatama, fakafifine, fakaleiti, gender diverse, genderqueer, mähū, non-binary, palopa, takatāpui⁷³, tangata ira tāne, trans, transsexual, vakasalewalewa and whakawahine.

Not all gender diverse people conform to binary gender norms. Gender diverse people may identify as binary or non-binary. Each person's gender expression (how they present to the world) is unique. Individual transition goals may include different aspects of social, mental health, medical or surgical care.

It is important to note that sexual orientation or gender diversity should not be 'treated' by therapy or any other means. However, people of the rainbow community have varying experiences of sexuality and gender, so it may be useful to acknowledge whether or not their mental health is impacted by their experiences.⁷⁴ A person's sexuality and gender experience may not be relevant to the reasons a person has

⁷⁰ RANZCP, *The relevance of religion and spirituality to psychiatric practice*. June 2018.

Position Statement 95. <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/the-relevance-of-religion-and-spirituality-to-psyc>

⁷¹ Rainbow is an inclusive term used to refer to anyone with a diverse sex, gender identity or sexual orientation. The acronym LBQTQIA+ (including but not limited to lesbian, gay, bisexual, transgender, queer, intersex, asexual) is often used to refer to rainbow people.

⁷² Fraser, G. (2019). *Supporting Aotearoa's rainbow people: A practical guide for mental health professionals*. Wellington: Youth Wellbeing Study and Rainbow YOUTH.

⁷³ The term 'takatāpui' embraces all Māori with diverse gender identities and sexualities. Within that broad definition, takatāpui has deeper meaning for those who have claimed it. *Kerekere, Elizabeth (2015) Takatāpui: Part of the Whānau*. Auckland: Tīwhanawhana Trust and Mental Health Foundation.

⁷⁴ Mental Health First Aid Australia. *Considerations when providing mental health first aid to an LGBTIQ+ person*. Melbourne: Mental Health First Aid Australia; 2016.

engaged with mental health services. On the other hand, some rainbow people experience distress as a result of the discrepancy between their gender identity and the sex that they were assigned at birth (often referred to as gender dysphoria)⁷⁵ or their sexual orientation. If it is relevant, acknowledging this can enrich a person's support in mental health services. When engaging with a member of the rainbow community in mental health services a clinician or service may also need to consider intersectionality and minority stress.

Intersectionality⁷⁰ is a concept that acknowledges the fact that people who experience one form of marginalisation, may also experience other forms of marginalisation, based on their ethnicity, socio-economic status, gender expression and sexual orientation. These other forms of marginalisation may contribute to the development of mental distress and when combined have a compounding negative impact on a person.

Minority stress⁷⁰ is how the external world affects the internal world – societal stigma and discrimination create a hostile and stressful environment for sex, sexuality, and gender diverse people. In order to address the high rates of mental health distress among rainbow people, we need to intervene at two levels – at the societal level, to reduce stigma and discrimination (including in health settings), and at the individual level, to support sex, sexuality, and gender diverse people as they face stress and adversity.

For further information about what else to consider when providing care and support to a person of the rainbow community, see RainbowYOUTH's (2016) *Supporting Aotearoa's Rainbow People: A Practical Guide for Mental Health Professionals*.

4.2 Section 6: Use of interpreters

Section 6(2) of the Act requires a court, tribunal, or person exercising any power under the Act to ensure that an interpreter is provided for a person, if practicable, and if the first or preferred language of the person is a language other than English. First or preferred languages may include Māori and New Zealand Sign Language, which are both official languages of New Zealand. Appropriate interpreters may also be provided if the person is unable to understand English because of a physical disability.

In practice, section 6(2) of the Act means that the wishes of the person should be sought, particularly prior to any court or tribunal proceeding. It should not be assumed that a person is happy to communicate in English simply because they are able to do so. Section 6(2) of the Act also recognises that people are entitled to choose to communicate in another language. The court, tribunal, or person exercising any power under the Act must also ensure, as far as is reasonably practicable, that the interpreter provided is competent.

The service must provide means and access to sufficient numbers of appropriately trained interpreters for the proposed patient or patient, where practicable. The Act separates the requirement that an interpreter be sought and the requirement that the interpreter be competent into sections 6(2) and 6(3) respectively. This recognises that sometimes a competent interpreter, whether by accreditation as an interpreter,

⁷⁵ <https://www.health.govt.nz/your-health/healthy-living/transgender-new-zealanders>

membership of an industry body (such as the New Zealand Society of Translators and Interpreters), employment as an interpreter, or otherwise will not be available.

A situation may be that it is not reasonably practicable to engage a competent interpreter. However, an ‘amateur’ interpreter who is fluent in the person’s language and willing to act as an interpreter may still provide assistance to the person.

All efforts should be made to help a patient understand their rights, what to expect, and their safeguards. Ideally an interpreter will sit down with the patient and go through their rights or any information that requires translation with them, rather than simply handing a patient a translated pamphlet and expecting the patient to read and understand it.

Section 6(2) of the Act also recognises New Zealand Sign Language as an official language of New Zealand. It is important to note that many people within the Deaf community use sign language as their first language and their main source of communication. People in this community see themselves as a distinct culture, and experience unique pressures that affect their mental health.⁷⁶ Mental health services should be responsive to people, patients and proposed patients who are Deaf by ensuring that a competent interpreter is available to them, and by ensuring that staff members are aware that a Deaf individual’s culture surrounding their deafness has specific relevance and meaning.

A registered New Zealand Sign Language interpreter is considered to be a competent interpreter for the Deaf. An updated list of registered New Zealand Sign Language interpreters can be obtained from regional Deaf Association offices or the Sign Language Interpreters Association of New Zealand (SLIANZ).

⁷⁶ Ministry of Health. 1997. *Moving Forward*. Wellington: Ministry of Health 42–43.

5 Section 7A: Consultation with family/whānau, ongoing obligation to work with families

Section 7A of the Act reinforces the importance of family/whānau as a crucial dimension in the overall well-being/haoura of Māori (see section 4.1.1) and non-Māori and creates an ongoing obligation on health practitioners and responsible clinicians to consult with and involve family/whānau in decisions made concerning assessment and treatment.

Section 7A states that a health practitioner or responsible clinician **must** consult with family or whānau during the compulsory assessment and treatment process, unless it is not in the 'best interests' of the patient or proposed patient, or it is not 'reasonably practicable'. Comprehensive guidelines for consultation with family and whānau can be found in the Ministry of Health publication *Involving Families: Guidance Notes*.⁷⁷

The purpose of consultation with family/whānau is to:

- strengthen family/whānau involvement in the compulsory assessment and treatment process
- enhance the family/whānau contribution to the patient or proposed patient's subsequent care
- go some way towards addressing family/whānau concerns about information sharing and treatment options
- help facilitate ongoing family/whānau involvement in Mental Health Act processes such as clinical reviews of treatment or court hearings.

When a health practitioner or responsible clinician is establishing whether family/whānau consultation is in the best interests of the patient or proposed patient, they must first consult the patient or proposed patient. A health practitioner or responsible clinician must apply the relevant parts of these guidelines when deciding:

- when and how to engage with a family/whānau or the patient or proposed patient
- whether engagement with family/whānau is reasonably practicable

⁷⁷ Royal Australian and New Zealand College of Psychiatrists. 2000. *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes*. Wellington: Ministry of Health.

- whether engagement with family/whānau is in the best interests of the patient or proposed patient.

The clinician must acknowledge the relationships that a patient or proposed patient has with their family and whānau, a principal caregiver, or other person and support network that they trust. Where consultation with family/whānau is not practicable or in the best interests of the patient, the clinician should ask the patient or proposed patient if there is a person or support network who knows them well and is involved with their ongoing health and care. It is possible this person or support network might meet the definition of family/whānau as discussed below in section 4.2.

In addition to section 7A, patients and proposed patients have the right to the company of others (section 71), the right to receive visitors and make telephone calls (section 72), and the right to receive and send letters and postal articles (section 73 and 74). Services must facilitate these rights. It is important that the person who is engaged with mental health services, has the freedom to reach their close connections (family/whānau or friend), and that the family/whānau and friends can reach the individual, while the person is under the Act.

Consultation with family/whānau is an ongoing process. Although the Act requires consultation at certain times, it should occur through all phases and stages of the assessment/treatment process. It is recommended that a health practitioner or responsible clinician consults or attempts to consult:

- when making significant treatment decisions
- at each juncture in the compulsory assessment and treatment process
- when considering discharge from the compulsory assessment and treatment process
- when developing a relapse prevention plan.

Consultation may require the health practitioner or responsible clinician to disclose a patient's or proposed patient's personal and health information to family/whānau. This is particularly necessary when developing a treatment, discharge or relapse prevention plan in which family/whānau will be involved in maintaining a person's wellness in the community.

The disclosure of information for the purposes of consultation under section 7A **is not** a breach of the Privacy Act 1993 or Health Information Privacy Code.⁷⁸ However, it is desirable to discuss the consultation process with the patient or proposed patient in advance, so they understand the purpose of consultation and the extent to which information will be shared.

⁷⁸ See sections 7 and 53 of the Privacy Act 1993.

Reasonable consultation should include clinicians working with the patient and family/whānau to identify a family member possibly the principal caregiver, early in the process to be the point of contact for family/whānau. Equally the family/whānau should also be given the name of a contact person from the treatment team to facilitate consultation. It is important to record what has been done to facilitate practicable contact with the family /whānau and who has the responsibility of contacting them. Sometimes relationships between family/whānau and clinical teams can become damaged. In such cases, it is important to rebuild relationships with the family/whānau to facilitate continued consultation and engagement and/or establish alternative supports.

Consultation at the different stages of the compulsory assessment and treatment process is likely to assist the responsible clinician in making decisions at those stages. It may also increase family/whānau awareness of and/or involvement in, and contribution to, court hearings under the Act. If a person has presented to mental health services at a late stage of their illness, when the likelihood of successful consultation has been diminished due to strained family relationships, it may be beneficial to encourage re-engagement with family members as the person becomes well.

The names of family/whānau members consulted should be recorded on the initial assessment record form, and the nature of the consultation recorded in the patient's or proposed patient's clinical file.

The health practitioner or responsible clinician should obtain a patient's or proposed patient's consent to consult family/whānau whenever possible, but patient consent is not always required, such as when a patient is acutely unwell or lacks capacity to consent. The requirement to consult does not mean a patient or proposed patient forfeits their right to confidential care and treatment. Patients' and proposed patients' rights and the protection of those rights continue to be paramount and a major philosophical tenet of the Act.

The requirement to consult with family and whānau should ensure the health practitioner or responsible clinician makes more informed decisions. However, the section 7A requirement to consult does not mean all family/whānau concerns about the compulsory assessment and treatment of the patient or proposed patient will necessarily be addressed. It is possible the requirement will raise family/whānau members' expectations about the extent of their role in clinical decision-making and involvement in daily decisions about the care of their family/whānau member.

Where family/whānau have been consulted to develop a treatment, discharge or relapse prevention plan in which they will be involved in a person's continuing care, a clinician may share a copy of the plan with those whānau members most closely involved in delivering that care. This is a permitted disclosure of information for the purpose for which it was collected.⁷⁹

⁷⁹ Health Information Privacy Code 1994, rule 11(c).

The responsible clinician should also make family/whānau and/or the principal caregiver aware that they may contact a district inspector regarding any legal processes of the Mental Health Act.

5.1 Who must consult

Section 7A places the requirement to consult directly on the health practitioner or responsible clinician. However, other clinical staff (such as a DAO, care manager or cultural worker). Kaiarahi/Whānau Ora Navigators and peer support workers may, because of a pre-existing relationship with the patient or proposed patient and family/whānau, have important roles in facilitating the consultation.

It is also, therefore, the responsible clinician's responsibility to ensure that consultation is ongoing, responsive to the needs of the patient or proposed patient, and responsive to cultural values.

5.2 Who to consult

5.2.1 Defining 'family/whānau'

Definitions and understandings of family/whānau vary and are informed by different cultural backgrounds and practices. Almost always, the most important perspective for defining family/whānau is that of the patient or proposed patient.

The following definition is only one of many possible definitions, but the Ministry of Health recommends health practitioners and responsible clinicians use it to help avoid confusion and for consistency across the country.

5.2.2 Recommended definition

'Family/whānau' is a set of relationships a patient or proposed patient recognises as their closest connections, whether it be a collective or an individual. It is not limited to relationships based on blood ties, and may include any of the following:

- the spouse or partner of the patient or proposed patient
- relatives of the patient or proposed patient
- a mixture of relatives, friends and others in a support network
- only non-relatives of the patient or proposed patient.⁸⁰

Where a patient's or proposed patient's definition of family/whānau differs, if the patient or proposed patient is competent to decide who their family/whānau is, then their definition must be accepted.

The Act requires compulsory notifications at various stages of the assessment and treatment process to welfare guardians and to principal caregivers. Such persons can be regarded as family/whānau for the purposes of consultation under section 7A, in

⁸⁰ Royal Australian and New Zealand College of Psychiatrists. 2000. *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes*. Wellington: Ministry of Health.

addition to other family/whānau members. Note that ‘principal caregiver’ is more closely defined than family/whānau (see 1.4 above).

5.2.3 Prior competently expressed wishes

There are a number of ways in which a patient or proposed patient may have expressed their wishes as to who to consult when they become unable to make decisions, what treatment they do or do not want in such situations, or who can make decisions on their behalf in certain circumstances. These include:

- crisis or treatment plans (see Standard 3.5 of the *Health and Disability Services (Core) Standards – Continuum of service delivery* (NZS 8134.1.3:2008))
- advance directives (see Code of Health and Disability Consumers’ Rights)
- enduring power of attorney (see Part 9 of the Protection of Personal and Property Rights Act 1988)
- personal orders under the Protection of Personal and Property Rights Act 1988, including appointment of a welfare guardian.

Clinicians should take steps to give effect to prior competently expressed wishes, when reasonably practicable and clinically indicated. Clinicians and clinical teams should also enable patients to express their wishes when they are well. This can be done through development of treatment plans, and/or assistance in developing an advance directive. The mental health advance preference statements⁸¹ referenced above in section 1.3.2 are one model that can be used. Clinicians and clinical teams should ensure these treatment plans, or advance directives, are with the patient’s notes so that they can be taken into account in future decision-making if the person lacks mental competence.. Teams should also enable discussion with family/whānau about such plans so that the patient’s prior competently expressed wishes are given the greatest chances of being acted upon.

5.2.4 Deciding disputed definitions of family/whānau

In cases of doubt or dispute, the DAMHS is responsible for deciding:

- whether the patient or proposed patient is sufficiently competent to determine who is their family/whānau
- who the patient’s or proposed patient’s family/whānau is for the purposes of section 7A.

The DAMHS will make this decision based on advice from the responsible clinician, health practitioner or key worker.

If the patient or proposed patient identifies as Māori, the DAMHS should seek advice from Māori health workers and cultural support staff. The DAMHS should consult other knowledgeable parties, for example, the patient’s or proposed patient’s usual general practitioner, key worker, Māori health worker, kaumātua, cultural support

⁸¹ <https://www.southernhealth.nz/getting-help-you-need/mental-health-and-addictions/mental-health-advance-preferences-statement>

staff, Māori consumer advisory groups, Māori advisory committee, other Māori providers of services to the patient or proposed patient, or a district inspector.

In urgent circumstances, the health practitioner completing sections 10 and 11 of the Act is responsible for making this decision for the purposes of the Act.

5.3 What consultation is

5.3.1 Definition of ‘consultation’

In practical terms, consultation in this context describes engagement between the health professional, responsible clinician (and clinical team) and patient’s or proposed patient’s family and whānau in a therapeutic process. Consultation is a two-way ongoing process, and ‘should not be limited to achieving formal obligations.’⁸²

Consultation does not require the parties to agree and does not require negotiations towards agreement. However, negotiations and agreement might occur as the tendency in consultation is for the parties to work towards consensus.⁸³

Meaningful consultation has been described by the courts to consist of the following stages and may occur in a variety of ways, including in person or by phone (including by teleconference). The party required to consult:

- begins consultation in the formative stages of a process by notifying affected or interested parties of a proposed (not final) decision or action
- provides the affected or interested parties with a reasonable amount of time in which to respond to the notification (which will depend on the urgency of the decision or action)
- may have a working plan in mind that they inform the affected or interested parties about, but must keep an open mind and be ready to change or start afresh should that be required
- provides the affected or interested parties with a reasonable opportunity to form and state their views in a safe and open environment
- considers properly the representations of the affected or interested parties before deciding what will be done
- notifies the affected or interested parties of the outcomes of the consultation.

5.3.2 Deciding about consultation

A health practitioner or responsible clinician must consult the patient or proposed patient to ascertain their views about consultation with family/whānau. It is important that a health practitioner or responsible clinician does not close their mind to alternative contacts before consultation occurs.

A patient or proposed patient may refuse permission for a health practitioner or responsible clinician to consult family/whānau. In this situation it is up to the

⁸² Te Arawhiti (2018). Guidelines for engagement with Māori.

⁸³ *Wellington Airport v Air New Zealand* [1993] 1 NZLR 671.

practitioner or clinician to then decide whether consulting family/whānau would be in the best interests of the patient or proposed patient (see 5.5.1 below), and ask the patient who they would like to sit in place of their family/whānau.

Even if the circumstances are urgent, a health practitioner or responsible clinician should still consult with the patient or proposed patient to seek their views about the consultation. However, given the urgency the clinician may decide it is not in the best interests of the patient or proposed patient, or is not reasonably practicable to consult family/whānau at that time. This does not preclude the practitioner or clinician from communicating with the family/whānau at the earliest opportunity after a decision has been made and before further action is taken.

5.4 How to consult

5.4.1 General comment

A health practitioner or responsible clinician who consults family/whānau must use their discretion to decide how much information to disclose to the family/whānau. The practitioner or clinician must consider how much information the family/whānau needs to make informed and useful responses to the proposed course of assessment or treatment. The practitioner or clinician may have a working plan in mind, but must keep an open mind and be ready to change or start afresh if this is required.

For consultation to be meaningful it must occur before the health practitioner or responsible clinician makes a decision. Discussions after a decision has been made are no longer consultation, but rather information sharing.

Consulting family/whānau as part of the assessment and treatment process is generally ongoing to allow views to change as new information is exchanged. If a significant period has elapsed or new information has come to light since a consultation, the health practitioner or responsible clinician should not rely on that consultation but consult afresh.

Further consultation may be particularly relevant when the patient moves from the care of one clinician to another. The practitioner or clinician should outline the likely changes and the opportunities family/whānau will have to consult the new clinician or attend future meetings or court hearings.

5.4.2 Māori

Māori place a high value on the collective values and relationships within whānau, hāpu and iwi and the “interwoven relationship” between whānau, hāpu iwi and the haoura or wellbeing of an individual whānau member⁸⁴. The general emphasis the Act places on the individual patient or proposed patient conflicts with the ‘whānaungatanga’ concept of interdependence and the interconnectedness between all members of the whānau, including the tangata whai ora.⁸⁵ However, sections 5(2)(a) & (b) of the Act do

⁸⁴ Elder, H. *Te Puna a Hinengaro: he Tirohanga ki a Aheinga The Wellspring of Mind: Reflections on Capacity from a Maori Perspective*, Chapter 3, Mental Capacity Law in New Zealand, Reuvecamp I and Dawson J (General eds). 2019.

⁸⁵ ‘Tangata whai ora’ means ‘the one who is seeking wellness’.

emphasise the importance of these connections and relationships by requiring services to be delivered with proper recognition of these relationships, and the importance of these relationships on an individual's wellbeing (see section 4.1 above regarding cultural identity).

A health practitioner or responsible clinician should not make decisions about Māori individual interests and/or whānau interests solely. Whenever possible they should work alongside Māori health workers, kaumātua, cultural support staff, tāngata whai ora advocacy services, Māori advisory committees or other Māori providers of services to tāngata whai ora. For concerns regarding privacy requirements see section 4.1.2 above.

To implement section 7A appropriately and to ensure mental health staff work effectively with whānau, staff may need:

- specific training resources
- appropriate cultural expertise
- support within the organisation.

Māori do not all share the same views and practices (tikanga). Every whānau needs recognition and to be able to participate in care, assessment and treatment processes in a culturally safe environment. It is suggested that Māori and non-Māori professionals need to work with whānau to develop understandings meaningful to that whānau.⁸⁶

To reduce the risk of inappropriate service delivery and to ensure the patient or proposed patient remains culturally safe, mental health services may need to:

- ensure kaumātua are involved
- seek guidance from appropriate Māori support staff such as Māori health workers, Māori advisory group members or tāngata whai ora advocates
- seek advice about tikanga Māori
- train staff in cultural safety
- ensure staff are flexible and responsive.

For this involvement to be meaningful and effective, working relationships between mental health service staff and Māori support staff must be developed and maintained well in advance of any crisis intervention.

Family/whānau consultation in practice can reflect the five principles of Te Tiriti o Waitangi: tino rangatiratanga, equity, active protection, options, and partnership. For example:

- Tino rangatiratanga, which share ties with supported decision making in some respects, may help a patient or proposed patient engage in self-determination and live by their values.

⁸⁶ Elder, H., Tapsell, R. 2013. Chapter 14. In: J Dawson, K Gledhill (eds). *New Zealand's Mental Health Act in Practice*. Victoria University Press, Wellington).

- Equity might require that the responsible clinician be mindful of how connection with family/whānau influences the health outcomes of a patient or proposed patient. That includes considering both therapeutic value of engaging a support network, and the potential to harm a patient if they are socially isolated.
- Active protection might see that a responsible clinician protects the relationships a patient or proposed patient has with their family/whānau, and other support networks.
- Options, similar to tino rangatiratanga in the above example, might offer the patient or proposed patient what they want for their treatment and how they wish that their family/whānau be engaged.
- Partnership, where the responsible clinician, patient or proposed patient, and their family/whānau continually work together, respecting one another's views, for the betterment of the patient or proposed patient.

These examples are not limited, and clinicians are encouraged to work with Māori and kaupapa services to seek out best practice methods so that the care provided is a good fit for the person in front of them.

5.4.3 Other cultures and identities

Similar consideration must be given to the cultural needs of a patient or proposed patient, and their family/whānau, when they identify as a Pacific person or from another culture or ethnicity.

Additionally, consideration must be given to the needs of a patient or proposed patient where they may require different supports based on their gender and/or sexual identity. For example, people who are transgender may have experienced discrimination from family/whānau, health services, as well as the wider society. In this way, clinicians must again be mindful of a patient's or proposed patient's preferred support networks.

Clinicians are encouraged to work alongside the respective teams where a person might not neatly fit into mainstream services and Western-focused practices. This is reflected under sections 65 and 66 of the Act; where patients and proposed patients are entitled to have their cultural identity etc. respected, and that they have the right to treatment, which includes any other health care that is appropriate to their condition.

5.5 Reasons for not consulting

5.5.1 'Best interests'

The importance of the 'best interests' concept is that the interests of the patient or proposed patient come ahead of anybody else's interests. 'Best interests' is an expression used elsewhere in the Act (for example, section 19 and clause 2 of the First Schedule).

To determine a patient's or proposed patient's best interests, a health practitioner or responsible clinician must consider all relevant clinical or personal information, which includes:

- the mental state of the patient or proposed patient
- the patient's or proposed patient's competence to make decisions about their care
- any advance directives the patient or proposed patient may have made
- why the patient or proposed patient wants their family/whānau excluded
- the patient's or proposed patient's clinical and family/whānau history
- any previous contact the patient or proposed patient has had with other mental health service providers
- the likelihood of the family/whānau having information not available from other sources.

The interests of a patient or proposed patient and their family/whānau may conflict. The 'best interests' assessment means the health practitioner or responsible clinician must resolve the conflict in favour of the patient or proposed patient about or for whom they are making a decision.

A health practitioner or responsible clinician must have reasonable grounds for deciding that consultation with a patient's or proposed patient's family/whānau is not in their best interests (under section 7A(3)(b) of the Act). Deciding whether or not to consult a patient or proposed patient's family/whānau should follow consultation with the patient or proposed patient, having engaged in supported decision making or referring to an advanced directive if available. If it is decided that it is not within the best interests, clinicians should report the reasoning behind that decision. Simply writing 'not in best interest' or 'not practicable' is not sufficient.

If the health practitioner or responsible clinician decides consulting family/whānau is not in the patient's or proposed patient's best interests, they must take into account that:

- they may still seek information from the family/whānau
- the family/whānau may continue to provide information to the practitioner or clinician
- the family/whānau may be given information that was collected for the purpose of being disclosed to the family/whānau
- the family/whānau may be given information if the practitioner or clinician considers it will prevent a serious threat to the life or health of the patient or family/whānau members.

If family/whānau will be providing the ongoing care of a discharged patient, it will normally be in the patient's best interests that family/whānau be consulted and have the appropriate treatment information disclosed to them.

5.5.2 'Reasonably practicable'

The term 'reasonably' brings a measure of objectivity to a decision: with knowledge of the same facts, would a reasonable, responsible clinician make the same decision?

The term ‘practicable’ has been considered in other jurisdictions in relation to family/whānau involvement in mental health care.⁸⁷ It acknowledges that, for various reasons, there are circumstances in which we must be content with less than the ideal, and the degree of compromise calls for judgement and common sense.

Thus when considering whether consultation is ‘not reasonably practicable’ the health practitioner or responsible clinician needs to consider objectively whether consultation is feasible. They may consider:

- whether the situation is urgent (such as if the patient or proposed patient is acutely unwell and the clinician needs to act quickly)
- the time it will take to contact family/whānau members as well as the time required for family/whānau members to form their views
- any other disadvantage (but should balance any disadvantages with the potential benefits to the patient or proposed patient).

For assessments occurring after hours, the time of day is not necessarily a reason for not consulting family/whānau. An after-hours assessment would invariably be an urgent assessment and family/whānau consultation may be highly relevant to the immediate safety and risk issues.

Likewise, resource constraints (such as a lack of clinician time) will rarely of themselves justify a ‘not reasonably practicable’ decision. Urgency combined with resource constraints may limit the time available for consultation but will not in most cases make it ‘not reasonably practicable’.

If in doubt, a clinician can always check with the family/whānau as to what they also consider ‘reasonably practicable’. For example, it would be pre-emptive to assume that it is not reasonably practicable, or that the family/whānau would be unhappy to be called in the middle of the night. This can be resolved by consulting the family/whānau as to what they would prefer.

Beginning 1 July 2020, the Director of Mental Health will require that any time a responsible clinician records family/whānau consultation was not conducted because it was ‘not reasonably practicable’, the reasons for this must be documented in the assessment form and record of this must be provided to the relevant Director of Area Mental Health Services. Directors of Areas Mental Health Services will be expected to provide this record to District Inspectors and the Director of Mental Health as requested.

With respect to planned assessments occurring under section 76 of the Act, it will rarely be justifiable to record that family/whānau were not consulted because it was ‘not reasonably practicable’ as these assessments can be scheduled and arranged in advance in a manner that accommodates the needs of the family/whānau to participate. In the event a clinician records family/whānau consultation as ‘not reasonably practicable’ with respect to a section 76 assessment, the clinician is expected to also record the details and explanation of why the consultation was ‘not reasonably practicable’ As

⁸⁷ *R (on the application of E) v Bristol City Council* [2005] EWHC 74 (Admin).

required by the Director of Mental Health, and a record must be provided to the Director of Area Mental Health Services.

6 Part 1: The compulsory assessment process

If less restrictive mental health interventions have failed, and a person appears to be mentally disordered, compulsory assessment under Part 1 of the Act may be appropriate.

Any person can make an application for assessment under section 8 of the Act, provided they meet the criteria in sections 8A and 8B. Please note a section 8A application can only be made after a section 8B certificate is completed (see *Figure 1*).

As the application process is a complex and significant intervention, the Ministry recommends that anyone concerned about a person's mental health contact a crisis assessment team and seek the assistance of a duly authorised officer (DAO). The Ministry maintains a list of mental health crisis phone numbers on its website.⁸⁸

6.1 The role of the Duly Authorised Officer

A duly authorised officer (DAO) is a health professional granted particular powers under the Act and appointed by a Director of Area Mental Health Services (DAMHS). DAOs must have appropriate training and experience to be responsive and empathetic towards a person's mental health concerns. A supportive decision-making approach can begin with a person's interactions with a DAO.

A DAO will often be the first point of contact for a person with concerns about their own mental health or about someone else who appears to be experiencing a mental health problem. Therefore, DAOs have the opportunity to make a difference in how a person and their family/whānau experience the Mental Health Act processes by engaging in a way that supports trust and collaboration. For example, it is important that DAOs can recognise and support the specific cultural and linguistic identity, such as if someone identifies with tikanga and Te Reo Māori (the customs/beliefs and language of Māori). This can also be extended to respect for a person's gender identity by using their preferred name and pronoun.

The DAO provides general information, advice, and practical assistance as to how the Act operates; information about the services available; and assistance in arranging assessments, and if required, directing police to assist in taking people to a locality where an assessment can take place. DAOs should also ensure that people are aware of the services of district inspectors, and how to access these.

Where there is an interpretation barrier, such as the person's first language is not English, DAOs must comply with section 6 of the Act, whereby a court, tribunal, or

⁸⁸ www.health.govt.nz/yourhealth-topics/health-care-services/mental-health-services/crisis-assessment-teams

person who is administering the Act must ensure that a competent interpreter is available to assist the person. It is important that a proposed patient understands the information available to them and has someone available to explain anything that is unclear. Such practice reflects supported decision making, a process that the Ministry of Health are emphasising be used during compulsory assessment and treatment.

The DAO role coordinates with proposed patients, patients, their family/whānau or caregiver, responsible clinicians, DAMHS, Police, and any other person who may be involved with the proposed patient or patient's assessment and treatment. The role that DAOs perform is broad. DAOs largely focus on proposed patients and patients, whether or not they require an order under the Act, or to assess whether or not a patient requires admission to hospital in light of deteriorated health within the community. Some of the tasks that DAOs may be involved in will include:

- Section 38(3), arranging non-urgent medical examinations. DAOs will either arrange or assist someone in arranging a medical examination (section 8B), and an application for assessment under the Act (section 8A).
- Section 40(2)(b), section 50(3), and section 51(1), where a DAO will take reasonable steps to return a patient to hospital if they went absent without leave, if a special patient has had leave cancelled, or if the DAMHS directs a patient be temporarily returned to hospital, respectively.
- Responding to requests from Police. For example, if a person who had been held by Police for the purpose of a medical examination for a suspected mental disorder, a DAO will be called to assist Police in organising a medical examination for the detained person. It should be noted that if a person is detained by Police on the suspicion that they may be mentally disordered, the person must be responded to within six hours.

This is a subset of the range of work and roles DAOs perform. More guidance relating to the exercise of DAO powers, particularly in relation to the compulsory assessment process, is contained in the Ministry of Health publication *Guidelines for the Role and Function of Duly Authorised Officers* (Ministry of Health 2012).⁸⁹

6.2 Threshold for application for compulsory assessment

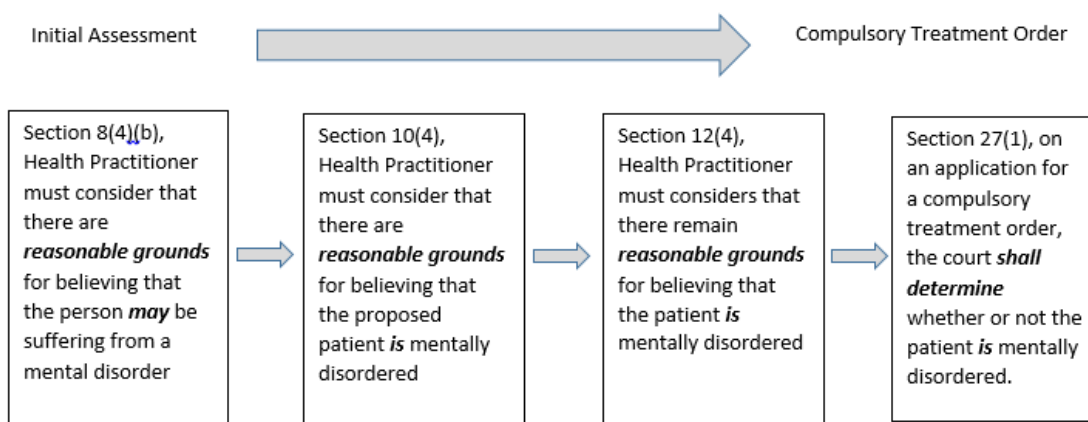
The Act requires a lower threshold for initial application for compulsory assessment, than for making a compulsory treatment order. There is, however, opportunity at each stage of the assessment process for a health practitioner to release a person from further assessment if they are of the opinion that a proposed patient is not mentally disordered.

- Under section 8B(4)(b) of the Act, a nurse practitioner, medical practitioner or registered nurse working in mental health must 'consider that there are *reasonable grounds* for believing that the person *may be suffering from* a mental disorder' before issuing a certificate to accompany an application for compulsory assessment.

⁸⁹ <https://www.health.govt.nz/publication/guidelines-role-and-function-duly-authorized-officers>

- Under section 10(4) of the Act, the health practitioner issuing a certificate of preliminary assessment must consider that there are *reasonable grounds* for believing that the proposed patient *is* mentally disordered'. Section 10(3) of the Act, however, provides the option to *free* a proposed patient from further assessment and treatment if the health practitioner is of the opinion that the person is *not* mentally disordered. This is an important part of the assessment process and decision-making needs to be rigorous and holistic, considering all aspects of the proposed patient.
- Under section 12(4) of the Act, the responsible clinician issuing a certificate of further assessment must consider that 'there remain *reasonable grounds* for believing that the patient *is* mentally disordered'. Section 12(3) of the Act, however, provides the option to *release* a patient from compulsory status if the responsible clinician is on the opinion that the patient is *not* mentally disordered.
- Before issuing a certificate of final assessment, the responsible clinician must determine whether a patient *is* or *is not* fit to be released under section 14(1)(a) and 14(1)(b), respectively. Following *Waitemata Health*, this means that the responsible clinician must *believe* that the patient *is* or *is not* mentally disordered.
- Before a compulsory treatment order can be issued under section 27(1) of the Act, the court must 'consider whether or not the patient *is* mentally disordered'. Section 27(2) of the Act provides that if the court considers a patient as not mentally disordered, the patient will be released from compulsory status forthwith. Section 27(3), on the other hand, provides that if the court considers that the patient is mentally disordered, it must determine whether or not, having regard to all the circumstances of the case, it is *necessary* to make a compulsory treatment order.

The test of 'reasonable grounds for believing' may be derived both from the responsible clinician's examination of the patient and/or from information given by caregivers, family/whānau and third parties.



If at any time the responsible clinician becomes concerned that there may have been insufficient grounds for compulsory assessment, the next stage of the compulsory assessment process should be undertaken. A new assessment will override earlier legal

errors if the legality of the patient's detention is called into question,⁹⁰ therefore, preventing a successful application for a writ of habeas corpus.

Figure 1: Compulsory assessment and treatment

6.3 Applications for assessment: the role of duly authorised officers

A health practitioner certificate under section 8B of the Act must be obtained before an application for assessment can be completed under section 8A of the Act. The statutory time limits for the examination under section 8B and the completion of an application under section 8A must be strictly adhered to. The Act states that an application is made under section 8A when the DAMHS receives a filled-out application form that is accompanied by a certificate issued under section 8B. The date on the section 8A application cannot pre-date the section 8B certificate. The section 8B certificate states the date of the examination, which must be within the three days prior to the date of the 8A application. Once an application is made, a DAO may take all reasonable steps to facilitate an assessment examination under section 40(2)(a).

If no application for assessment has yet been made, and there are reasonable grounds for believing a person may be mentally disordered, under section 38(4)(d)(i) a DAO can take all reasonable steps to take the person to a medical practitioner for an examination if less-restrictive options of facilitating a medical examination have been exhausted.

In an urgent situation and as a last resort, a DAO can, under section 41 of the Act, request Police assistance to take a proposed patient to a nominated place for the purposes of an examination under section 10 of the Act. Services should refer to the Memorandum of Understanding between the New Zealand Police and the Ministry of Health, which provides guidance to members of the Police and health professionals administering the provisions of the Act, as well as any local agreements made under the Memorandum of Understanding.

6.46.4 Assessment examinations

Section 9(1) of the Act states that when the DAMHS or a DAO receives notice of an application made under section 8A, the DAMHS 'must make the necessary arrangements for the proposed patient to immediately undergo an assessment examination'.

6.4.1 Changes to section 9(1) by the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2016

It is important to note the requirement for the DAMHS to make the arrangements specified under section 9(1) is due to an amendment made under section 8 of the

⁹⁰ *B v Auckland DHB* [2010] NZCA 632; [2011] NZAR 135.

Mental Health (Compulsory Assessment and Treatment) Amendment Act 2016 (the Amendment Act), which came into force 31 January 2018. Prior to this amendment a DAMHS or a DAO was responsible for making such arrangements. This suggests that the making of arrangements for proposed patients no longer forms part of a DAO's role. If a DAO continues to make these arrangements, there is a risk that the DAMHS may be perceived to have not properly discharged their functions under the Act.

In recognition of the unfeasible requirements this amendment places on a DAMHS, guidance previously provided by the Director of Mental Health advises taking an expansive interpretation of the functions listed in section 9(2), through which a DAMHS may discharge their obligations under section 9(2) of the Act by “overseeing” and “approving” a DAO's performance of the tasks listed in section 9(2).

Prior to the Amendment Act, section 9(1) permitted DAOs to carry out the arrangements of section 9(2) with only the general direction of the DAMHS. Following the commencement of the Amendment Act on 31 January 2018, under an expansive interpretation, DAOs require a high level of oversight from their DAMHS in order to carry out the arrangements specified in section 9(2). The DAMHS will also remain liable for any decisions made or actions taken under section 9(1).

6.4.2 Section 9(2) requirements for assessment arrangements

Section 9(2) of the Act provides details about the arrangements required under section 9(1) of the Act. This includes a requirement to give the proposed patient a written notice explaining the purpose of the examination and detailing the place, time and the person conducting the examination (section 9(2)(c)). Section 9(2)(d) of the Act ensures that the notice given under 9(2)(c) are explained to the proposed patient in the presence of a member of the proposed patient's family or a caregiver in relation to the proposed patient or other person concerned with the welfare of the proposed patient. Moreover, section 9(2)(e) of the Act ensures, where necessary, that appropriate arrangements are made to transport the proposed patient at the right time to the place where the assessment examination will be carried out. And where necessary or desirable, that the proposed patient be accompanied on the journey with an appropriate person.

The DAMHS or DAO may not always be able to perform these functions personally but must ensure that necessary arrangements are made appropriate to the circumstances, including the urgency of the situation. For example, if a medical practitioner is acting under section 110 of the Act (powers of medical practitioner where urgent assessment is required), a phone call to the DAO or DAMHS is sufficient to decide who will carry out the assessment and where. The DAO can ask the medical practitioner to give the section 9(2)(c) notice to the proposed patient and explain what is to occur and their rights (see chapter 11).

Note that written information can be given on any paper, not necessarily the usual form used under section 9 of the Act. In an emergency, the proposed patient should be given as much detail as practicable, but it may not be practicable to give full written details. The clinician must make a reasonable judgement as to how much disclosure is practicable in the circumstances.

In making the necessary arrangements for an assessment examination under section 9(1) of the Act, a DAO may contact other health services (such as a general practitioner) to obtain information relevant to the assessment. The collection of such information by DAOs, and its disclosure to DAOs by health services, is permitted by legislation related to information privacy (the Health Information Privacy Code 1994, the Privacy Act 1993 and the Health Act 1956).⁹¹

If the proposed patient is assessed as not being mentally disordered, the DAO and other clinical staff of the mental health service concerned should take whatever further action is required to assist the individual who has been assessed. This assistance will normally include:

- the continuing provision of services to a patient who accepts them voluntarily
- assistance with transport from the place of assessment (if the person has been transported to the assessment).

6.4.3 Section 9(2)(d) explanation of notice of assessment

It is mandatory for an explanation of the purpose of the assessment to take place in the presence of a support person under section 9(2)(d). While non-compliance with this section has previously resulted in applications for *habeas corpus* being granted,⁹² the Court of Appeal has indicated that such a breach is insufficient to warrant nullification of the assessment process by granting the writ if the assessor has attempted to comply with the requirement.⁹³

During this process, all efforts should be made to ensure that interpreters are available, if the proposed patient's first language is not English, this necessary to satisfy the requirement for services to be delivered with proper respect for a person's language under section 5(2)(c) of the Act.

An assessor must offer to organise the attendance of a support person known to the applicant, such as a family member, caregiver or friend, if such a person is available. If no such person is available, an independent person not involved in the application or assessment and treatment process should be engaged. This should not be a mental health professional.

⁹¹ Section 22F of the Health Act 1956 states that a provider who holds health information must disclose that information to another person who is providing or is to provide health or disability services to a person.

⁹² *Keenan v DAMHS* [2006] 2 NZLR 572; *Chu v District Court at Wellington* [2006] NZAR 707.

⁹³ *Sestan v DAMHS, Waitemata District Health Board* [2007] 1 NZLR 767.

Provided this process is undertaken in good faith, it is unlikely to prejudice the validity of the application as other opportunities for clinical and judicial reassessment are available under the Act.⁹⁴ If a proposed patient strongly indicates that they do not want to comply with the requirement, their right to privacy should be respected.⁹⁵ Additionally, there may be situations where it would be unsafe to engage a support person.

6.4.4 Section 9(3) assessment examination to be conducted by a health practitioner

Section 9(3) of the Act describes the qualifications necessary to perform an assessment examination. The person must be a health practitioner who is either a psychiatrist approved by the DAMHS or, if no psychiatrist is ‘reasonably available’, a medical practitioner or nurse practitioner (not being the health practitioner who issued the certificate under section 8B(4)) who, in the opinion of the Director of Mental Health, is suitably qualified to conduct the assessment examination or assessment examinations generally. (Please note, section 9(4) allows the Director of Mental Health to delegate this function to the DAMHS).

‘Psychiatrist’ is defined within section 2 of the Act as ‘a medical practitioner whose scope of practice includes psychiatry’. A medical practitioner holding ‘scope of practice’ in any specialty must have completed vocational training and completed a post-graduate qualification approved for or relevant to the scope of practice.⁹⁶ Registrars are registered in a general scope of practice and do not fall under this definition. A nurse practitioner is a health practitioner who is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions and holds a current practising certificate.

‘Reasonably available’ is not defined within the Act. The expertise that is ‘reasonably available’ in a well-staffed urban centre may be very different to that in a more isolated rural area. Nevertheless, some consistency in the matter is expected. When considering the expertise that is ‘reasonably available’, the following context should be considered:

- who is able to be called
- the geographical location, or how far away the psychiatrist is
- the normal duty roster
- the clinical demands of the situation.

Practically, it may be too onerous for the DAMHS to consider the complexity of all assessments being undertaken, but if a less-experienced practitioner is assessing a case that they (or other members of the multidisciplinary team) feel is complex or particularly fraught, the circumstances and appropriateness of the health practitioner undertaking this assessment should be discussed with a DAMHS.

⁹⁴ *Sestan*, paragraphs [42]–[55].

⁹⁵ *Sestan*, paragraph [54].

⁹⁶ Medical Council. 2011. ‘Scopes of practice’. URL: www.mcnz.org.nz/get-registered/scopes-of-practice (accessed 1 October 2012).

The Ministry considers situations where a psychiatrist would not be reasonably available might include:

- after hours when there is no psychiatrist scheduled on the duty roster (for example, in small DHBs where the duty rosters are populated by registrars and Medical Officers [Special Scale])
- when the psychiatrist is absent for other reasons (such as ill health) and cannot be replaced by another psychiatrist
- when the psychiatrist is involved in other urgent work that means they are unable to attend the assessment in a timely manner and they cannot be replaced by another psychiatrist
- when the psychiatrist is too far away to be able to attend the assessment in a timely manner (for example in DHBs which cover a large geographical area).

Whenever possible (and particularly in the last two examples) the health practitioner conducting the assessment should discuss the particulars of the case over the telephone with the psychiatrist.

‘Suitably qualified’ is not defined, but as a minimum requirement the health practitioner (such as a psychiatric registrar, medical officer or nurse practitioner) should have at least two years’ experience in mental health. In a more difficult case that requires a fine degree of judgement, a more experienced senior practitioner with a greater level of expertise is needed. If there is concurrent substance use, consultation with a suitably qualified addiction practitioner may be appropriate.

It should be kept in mind that the person in charge of a hospital has the power to detain a person at a hospital for a maximum period of six hours under section 113(1) of the Act. If the proposed patient can be safely detained, it is preferable to detain them until the most suitable practitioner becomes available within a six-hour period.

The Act requires that copies of certificates completed following examinations at various stages of the compulsory assessment and treatments process (sections; 10, 12, 14, 29(3) and 76), be sent to key people namely the patient, any welfare guardian of the patient, the applicant for assessment, the patient’s principal caregiver and the primary care provider who usually attends the patient. It is important to note that these certificates or documents can be emailed to these above-mentioned people when required. Section 133(3)c states that “some other electronic means” can be used. Post has traditionally been used, however, it may no longer be the most appropriate method of communicating with patients or others mentioned in the act.

6.4.5 Reassessment following release from compulsory assessment

Section 10(3) of the Act notes that a further application under section 8A of the Act may be made at some time in the future. There may be circumstances in which a further application is required very soon after the first assessment. There is no time limit specified. A reapplication should be judged on the clinical and other information to hand. It should take into account the previous assessment made under section 10(3) of

the Act, and the circumstances of the assessment that found the individual not to be mentally disordered at that time.

6.5 Further assessment and treatment periods

The first and second periods of assessment and treatment are defined in the Act. The first period of assessment and treatment begins on the date that the patient receives a notice under section 11(1) of the Act and ends when five full days have passed, or earlier if the patient is reassessed for the purposes of section 12 of the Act before that date. The second period of assessment begins when a patient receives the notice under section 13 of the Act and ends when 14 full days have passed, or earlier if the patient is reassessed for the purposes of section 14 of the Act before that date. Following the initial assessment examination, all assessment and treatment decisions will be made by the responsible clinician assigned to the patient by the DAMHS.

Both sections 11 and 13 of the Act refer to the assessment and treatment periods as ‘commencing with the date on which the patient receives the notice and ending on the close of the [XX] day after that date’. The five- and 14-day periods should be calculated exclusive of the day on which the notice is given to the patient.⁹⁷ It is therefore recommended that the interpretation in the following example be adopted.

Day 0 – The day on which the notice is given to the patient:	1 January
Day 5 – The end of the fifth day:	6 January

This facilitates the management and appropriate assessment of individuals who receive notice of the compulsory assessment late in the day.

If, at any time during the first period (section 11(6)) or second period (section 13(6)), the responsible clinician considers that the patient is not mentally disordered and is therefore fit to be released from compulsory status, they must be immediately discharged. If there are good clinical reasons for truncating the five- or 14-day assessment periods, it is not necessary to let them run their full course.

6.6 Leave during the assessment and treatment process

Sections 11(5) and 13(5) of the Act enable a responsible clinician to allow a patient subject to compulsory inpatient assessment a short period of controlled leave (‘trial leave’) in the community, or to allow leave on compassionate grounds (such as to attend a tangi). Section 13(5) also applies when a responsible clinician has made an application for a compulsory treatment order.

If the leave is for eight hours or less between 8:00 AM and 10:00 PM, the Act requires it to be recorded (along with the terms and conditions of leave) in the patient’s clinical records (sections 11(5)(a) and 13(5)(a)). The patient’s contact details while on leave should also be recorded.

⁹⁷ *Re DI* [1996] NZFLR 713.

If overnight leave is granted it must be recorded in the clinical records (as with day leave), and the patient and the person in charge of the hospital must be given a written notice (sections 11(5)(b) and 13(5)(b)).

The written notice should include:

- the day that leave was granted
- length of leave
- when the patient is expected to return from leave
- the patient's contact details
- any terms and conditions attached to the leave.

6.7 Section 14: Certificate of final assessment

Section 14(4) of the Act governs the process of applying to the court for a compulsory treatment order. The opinion that the patient is not fit to be released from compulsory status⁹⁸ must be personally formed by the responsible clinician.

An application for a compulsory treatment order should be accompanied by reports from the responsible clinician and other health professionals involved in the care of the patient. This facilitates the timeliness of hearings and enables the judge to determine whether any further information is required before the date for the hearing is set. A judge is required to consider the evidence of both the responsible clinician and 'at least one other health professional involved in the case' when deciding whether to make a compulsory treatment order (section 18(4)).

A second health professional's evidence should do more than merely address the legal criteria of the Act. The evidence should also provide a comprehensive global view of the patient's health problems. The second health professional will most often be a registered mental health nurse. Guidance for nurses on report writing is provided in the New Zealand College of Mental Health Nurses (2012) publication *Guidelines for Mental Health Nursing Assessment and Reports* available on the College website (<http://www.nzchmn.org.nz>).

The responsible clinician must primarily address the criteria for compulsory treatment under the Act. The responsible clinician's and other health professional's reports should collectively include:

- comments on the patient's history of contact with mental health services, including severity of illness and response to treatment
- issues of substance use
- previous admissions under the Mental Health Act 1969, Mental Health (Compulsory Assessment and Treatment) Act 1992, Criminal Justice Act 1985, Criminal Procedure (Mentally Impaired Persons) Act 2003, Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Protection of Personal and Property Rights Act 1988, the Alcoholism and Drug Addiction Act 1966, or the

⁹⁸ See *Re LB* [1994] NZFLR 60.

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- comments on cultural, religious, gender, or other factors to do with someone's identity (including advice on whether an assessment has been conducted on those realms).
- advice on family/whānau and social support
- proposals for treatment, including information on community services (if applying for a community compulsory treatment order)
- justification of how the patient meets both limbs of the definition of 'mental disorder'
- any known specific risk and protective factors
- issues likely to be challenged in a defended hearing.⁹⁹

Other relevant material (such as reports prepared for previous hearings) may also be included. At this stage, it would be advisable to organise an interpreter if needed.

Following the final assessment, the patient may be held for up to 14 days after the time at which the second period would have expired (section 15(1)). This means that the maximum period for which a person can be held for assessment consists of a five-day first period, a 14-day second period and 14-day final period, totalling 33 days. This period may only be extended by the order of a court (section 15(2)).

6.8 Section 16: Review by a judge

Section 16 of the Act allows the patient to request a judge to review the patient's condition while the assessment process is in progress. If the judge is 'satisfied' that the patient is fit to be released from compulsory status, the judge discharges the patient forthwith and brings the process to an end. If not, the process of assessment continues. Furthermore, it falls to the person seeking the review and seeking discharge to satisfy the judge that the patient is fit to be discharged. In such a review, the judge is unlikely to have available the same amount of evidence as would be obtained at a full hearing. The process outlined in section 16 of the Act can be invoked at any point after a certificate of preliminary assessment requiring further assessment and treatment of the patient has been issued.

A judge has limited discretion in deciding whether or not to grant a review of a patient's condition. A judge can refuse to grant a review if a patient has had a previous review and there is evidence that there has been no change in the patient's condition (section 16(1C)).

⁹⁹ Stephen McCarthy and Dr Sandy Simpson. May–June 1996. *Running a case under the Mental Health Act 1992 and related legislation*. Paper presented at New Zealand Law Society Seminar, pp 14–16.

A judge is required to consider the evidence of both the responsible clinician and 'at least 1 other health professional involved in the case' when determining an application for review (section 16(4)). The second health professional will most often be a registered mental health nurse. Guidance for nurses on report writing is provided in the *Guidelines for Mental Health Nursing Assessment and Reports*, available on the College website (www.nzchmn.org.nz).

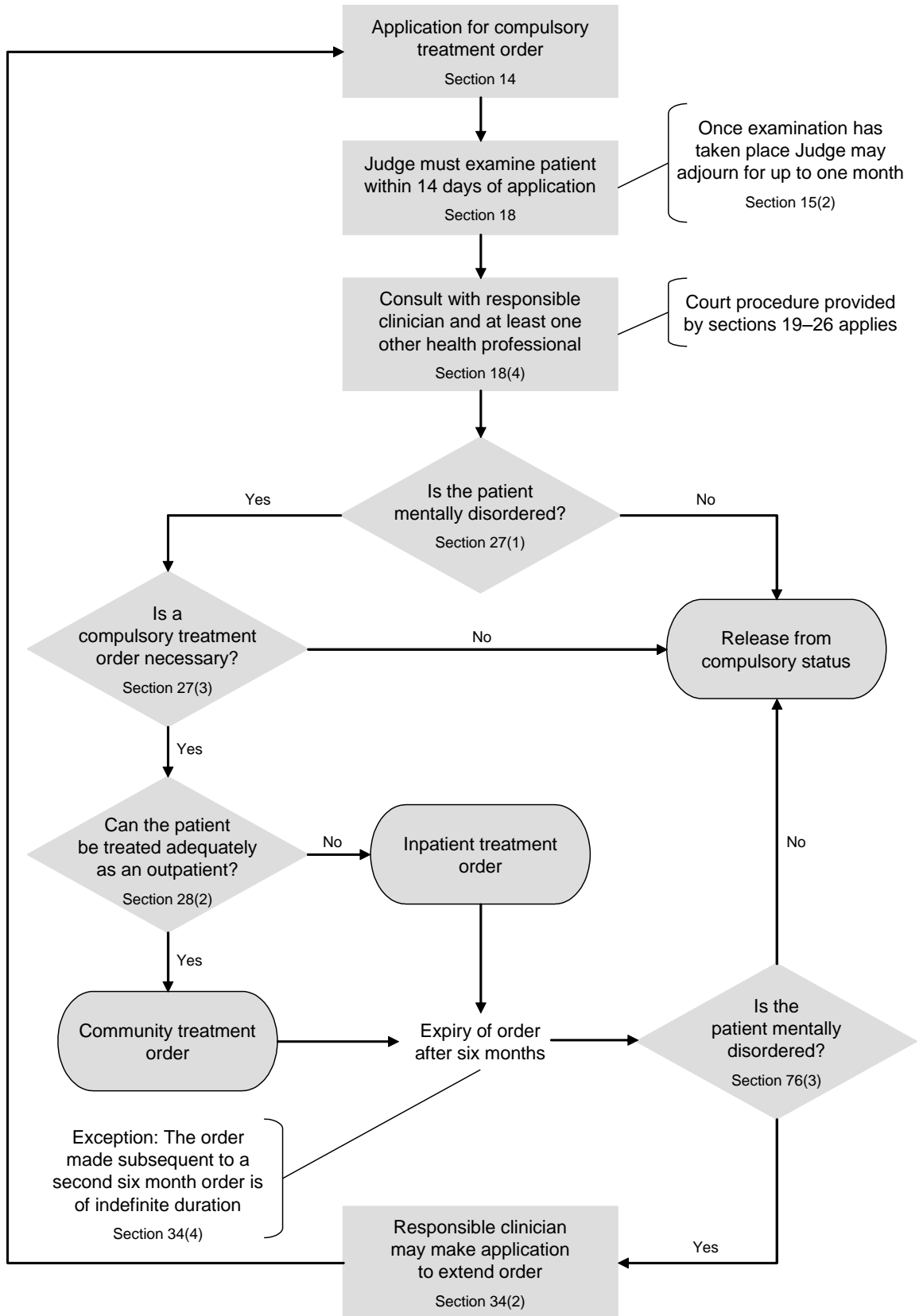
7 Part 2: Compulsory treatment orders

A compulsory treatment order is made by a court under section 28 of the Act. Such an order will only be made when a patient is mentally disordered, and the court considers that the order is necessary. This is the only time at which the necessity of an order is considered separately from the question of whether the person is mentally disordered, but necessity of treatment remains relevant to whether or not a person is mentally disordered in other contexts (see 2.2 'fit to be released' above).

A compulsory treatment order will be made if the responsible clinician applies to the court under section 14(4), and a Family Court Judge considers that the patient is mentally disordered and that an order is necessary (section 27). An order will be either a community treatment order or, if the patient cannot be adequately treated in the community or is a prisoner, an inpatient treatment order.

This process is outlined in Figure 2 on the following page.

Figure 2: Process for making compulsory treatment orders



7.1 Scope of a community treatment order

‘A community treatment order shall require the patient to attend at the patient’s place of residence, or at some other place specified in the order, for treatment by employees of the specified institution or service, and to accept that treatment’ (section 29(1)). Treatment is not defined but must be ‘treatment for mental disorder’. Before making such an order, the Court must be satisfied that the patient can be provided with ‘care and treatment on an outpatient basis that is appropriate to the needs of the patient’ (section 28(4)(a)).

The powers to enforce compliance with the order are outlined in the following sections of the Act.

- Section 29(1): The patient is required to attend and is ‘required to accept’ treatment for mental disorder at the direction of the responsible clinician during the first month of the community treatment order and thereafter if the patient gives informed and written consent to the treatment (section 59(2)(a)). If consent is not given, treatment may still occur if a psychiatrist (not being the responsible clinician) appointed by the MHRT considers that the treatment is in the patient’s interests (sections 59(1) and (2)(b); see chapter 10).
- Section 29(2): Employees of the service specified in the order are empowered to enter the specified place for the purpose of treating the patient.
- Section 40(2)(a): A DAO may take ‘all reasonable steps’ to take the patient to the place where they are required to attend for treatment.
- Section 41(5): The Police may be called to assist and may use necessary force to take the patient to the place where they are required to attend for treatment (see section 122B).
- Section 113A(4)(a): A warrant may be issued authorising Police to take a patient who refuses to attend to the place specified for treatment.

The scope of treatment should be clearly specified in the order (see section 7.3 below). A treatment plan may include a specific residential requirement, but this does not amount to a power to detain at the residence (see section 7.2 below).

It should be noted that, other than under section 29(3)(a), a person who is under a community treatment order can be treated as an inpatient for a period if they consent to such inpatient treatment. Consent should be obtained in writing and can be revoked by the person at any time.

7.2 Residence requirements under community treatment orders

Under a community treatment order, patients are not detained in a hospital or other place as an inpatient unless section 29(3)(a) has been invoked, and patients cannot be required to live at any particular address.

Increasingly, there is a blurred boundary between inpatient and community facilities. For example, community facilities may be planned to provide a high level of care equivalent to that provided in a hospital setting. Although a high degree of supervision may be provided in some residential settings, a community treatment order is not a basis for de facto detention in a community facility. A clear distinction must be maintained between an inpatient order (under which detention in a hospital mental health unit is authorised) and community treatment orders (under which detention is not authorised, except for short periods under section 29(3)(a)).

There is no statutory power for a responsible clinician to direct where a patient must live in the community.¹⁰⁰ However, a community treatment order made by a judge can specify that part of a patient's treatment can include supervision and monitoring which may only be provided in a particular type of residential facility, although this must not amount to de facto 24-hour detention. Therefore, there is a strong need to clearly specify the terms and conditions of a community treatment order (this applies equally to leave for inpatients under section 31) when a responsible clinician applies to a court for such an order. Moreover, a responsible clinician can direct where a special patient must live in the community if it is a condition of the warrant of ministerial long leaves.

If clinicians consider that particular arrangements relating to matters other than treatment would be beneficial to a person's recovery, they should attempt to gain the person's informed consent to those arrangements. It may be helpful to involve family/whānau to support decision making, or assist the patient to obtain peer support, or assist the patient to develop an advance directive, in order to set out more about what is important to the patient in relation to a residence. If all other suggestions are not possible an order under the Protection of Personal and Property Rights Act 1988 may be appropriate.

7.3 Terms of a community treatment order

The Act requires that the place of attendance for treatment, and the service or institution whose employees are providing the treatment, be specified in the community treatment order. There is no requirement that the treatment be specified. Nevertheless, it is recommended that the application for the treatment order specify the proposed treatment plan, in order that the court may make an order based on a clear plan of treatment.

¹⁰⁰ *Department of Health v D* (1999) 18 FRNZ 233; [1999] NZFLR 514.

When an application is made, the responsible clinician should state in writing exactly what is sought in the proposed order, setting out:

- the proposed treatment (medication or other treatment) that is considered necessary¹⁰¹
- the type/method of treatment as the patient's condition changes
- the location where treatment will take place
- the service(s) or institution(s) responsible for providing the treatment
- monitoring arrangements that will be put in place
- an indication of the services and support that will be available to meet the needs of the patient, additional to those specified as compulsory.

In making the order, the court should specify in writing the conditions of the order in a similar manner. The patient must be given a copy of the order (section 28(5)), which clearly specifies the requirements and conditions of the order.

Non-adherence to the specified terms of a community treatment order may be sufficient grounds to require the use of an enforcement power, an inpatient admission or a reassessment. There is no need to wait for serious danger to self or others, or seriously diminished capacity for self-care, to emerge if a responsible clinician recognises early warning signs of relapse emerging due to non-adherence to treatment.

7.4 Voluntary admissions during the term of a community treatment order

From time to time, a patient subject to a community treatment order may require and consent to an admission to hospital for treatment of their mental disorder as an inpatient. Because prolonged admissions to hospital, even as a voluntary inpatient, may be at odds with the making of an order for community treatment, it may be inappropriate to consider admission for more than a short period. In order to ensure that consent to such an admission is informed and that reassessment under section 29(3) of the Act is used when appropriate, the following requirements should be met.

- An inpatient admission during the term of a community treatment order, when the provisions of section 29(3)(a) or (b) do not apply, should occur **only** with the patient's fully informed consent, preferably in writing. This requires consideration of the patient's capacity to give informed consent.
- Whenever a patient is admitted as a voluntary inpatient during the term of a community treatment order, a district inspector must be notified (section 29(6)(d)). The district inspector can then check that the patient consents to the admission.
- In accordance with the scheme of the Act, which provides for limited compulsory admissions of patients subject to community treatment orders (see 6.5 below), it is

¹⁰¹ If it is likely that there will need to be a variation of treatment during the course of the order, this should be specified as far as possible. It is best not to name particular drugs or dosages, as medication may need to be altered. There needs to be enough flexibility to allow a reasonable degree of change.

suggested that such an admission should normally be for no more than 14 days. After this time, the situation should be reviewed and consideration should be given to either discharging the patient to the community and/or reassessing the patient under section 29(3) of the Act.

- If while the patient is admitted voluntarily, consent is withdrawn or the patient is sufficiently unable to give consent at any time, consideration should be given as to whether the patient should be reassessed under section 29(3) of the Act.

7.5 Compulsory admissions during the term of a community treatment order

Section 29(3)(a) of the Act permits a responsible clinician to direct that a patient subject to a community treatment order be treated as an inpatient for any one period of up to 14 days without the need to begin the assessment process and nullify the community treatment order. The responsible clinician must first seek to obtain the patient's consent to the inpatient treatment if it is practicable to do so. If the circumstances are urgent and the patient's responsible clinician cannot be contacted, the consultant psychiatrist on call can instruct a DAO over the phone to direct the patient (subject to a community treatment order) to be an inpatient. The form which directs the patient to be an inpatient should be signed by the responsible clinician or the consultant psychiatrist on call as soon as practicable.

If a direction is made under section 29(3)(a) after the first month of the currency of the patient's compulsory treatment order and the patient does not consent to the treatment proposed, the responsible clinician should obtain the opinion of a psychiatrist appointed by the MHRT that the treatment is considered to be in the interests of the patient.

It is not necessary to first obtain the opinion of a psychiatrist appointed by the MHRT that any change in treatment is in the interests of the patient in situations of urgency, if the particular treatment is necessary to save the patient's life or prevent serious damage to their health, or prevent the patient from causing serious injury to self or others (section 62).

A direction for inpatient treatment for any patient on a community treatment order cannot be made more than twice in any six-month period. If a patient requires either one period of more than 14 days or more than two 14-day periods as an inpatient during any six-month period, the responsible clinician must reassess the patient in accordance with sections 13 and 14 of the Act. The two 14-day periods cannot be consecutive.¹⁰²

When a patient is reassessed under section 29(3)(b) of the Act, the community treatment order ceases to have effect and the assessment proceeds under sections 13 and 14 of the Act.

¹⁰² *Director of Mental Health Services v Brown* FC Middlemore MA048/156/00 24 October 2000.

Both the written notice directing a change to inpatient status under section 29(3)(b) and a section 13 form are required to be completed by a responsible clinician, who must examine the patient. Under sections 58 and 59, the patient must then accept such treatment for mental disorder as the responsible clinician directs.

When a direction is made under either section 29(3)(a) or 29(3)(b) the patient can apply for a review under section 16 of the Act.

7.6 Overseas and domestic travel during the term of a community treatment order

From time to time, patients subject to a community treatment order wish to travel overseas and in some cases will seek the permission of their responsible clinician. The Act is silent on the issue of travel outside New Zealand while subject to a compulsory treatment order. However, in doing so, most patients will be breaching the terms of their order to 'attend a certain place for treatment'. In addition, if a patient becomes unwell while overseas they cannot be treated under the terms of their community treatment order. This can cause considerable distress to the patient and their family, and in some cases results in their repatriation to New Zealand, at considerable cost.

Domestic travel presents similar issues if it would cause a person not to attend at a specified place for treatment. Responsible clinicians have the mandate to tell patients on community treatment orders that they are not allowed to travel, if travel would breach the order.

Depending on a patient's level of acuity or the intensity or frequency of their treatment, it will be sufficient to advise some patients that they are not allowed to travel, and that to do so would breach the terms of their compulsory treatment order. For other patients, it may be worth considering whether an arrangement with another service can be reached to temporarily transfer the patient's compulsory treatment, or whether the person can be discharged from their compulsory treatment order. Taking a collaborative approach with the patient when they express a wish to travel is encouraged, as this is consistent with least restrictive practice.

7.7 Inpatient treatment orders

An inpatient treatment order requires the continued detention of a patient in a hospital for treatment for a mental disorder (section 30) unless leave is granted under section 31.

An inpatient treatment order can be converted into a community treatment order by the responsible clinician with a written notice under section 30(2), if the clinician considers that the patient can be treated adequately in the community. The place that the patient must attend for treatment should be specified in the notice. Once an inpatient treatment order has been converted into a community treatment order, prolonged compulsory inpatient treatment cannot be restored without a full compulsory reassessment under section 29(3)(b). However, a responsible clinician may direct that up to two non-contiguous 14-day periods of compulsory inpatient treatment occur within any six-month period (section 29(3)(a)).

7.8 Inpatient leave

Section 31 of the Act provides for a patient's responsible clinician to grant leave for a period of up to three months, subject to conditions determined by the responsible clinician. This period may be extended by a further three months.

The Act is unclear about when it is necessary to specify terms and conditions of leave in writing. When practicable, a leave form should be completed in each of the following circumstances:

- when the patient will be on leave overnight or longer
- when leave is being extended
- when there are any doubts about the ability or intention of the patient (and/or the caregivers) to comply with conditions of leave
- if the patient has a history of failing to return to the place of treatment after leave.

The patient and the person in charge of the hospital should also be given a copy of the leave form, similar to the process outlined at 5.5 above.

7.9 Release from compulsory treatment order

Section 64 of the Act requires that patients be kept informed of their legal status, and this should include appropriate written advice of their discharge from compulsory treatment status. Patients should also be given written confirmation if their compulsory treatment status lapses for any reason. It is recommended that release from compulsory treatment status be given in writing and it may be appropriate to use a certificate of clinical review form under section 76 of the Act for this purpose.

Clinicians are permitted to disclose the fact that a person has been or is going to be released from compulsory status to their principal caregiver.¹⁰³ This would be appropriate if the person's family/whānau, significant support network, or principal caregiver is expected to be involved in the person's continuing care. As a step towards supported decision making, clinicians can have more collaborative discussions with the family/whānau when a patient's compulsory treatment order is about to be reviewed. That is, having discussions with the patient and their support network earlier on in order to be clear on what is needed when a patient is discharged, or what else can be reviewed in their care plan in order to achieve greater wellbeing.

Section 35 provides that, when a person is no longer mentally disordered, they must be released from compulsory status 'forthwith'. Forthwith does not mean instantly, but as soon as reasonably practicable.¹⁰⁴ It is not justifiable to keep a person who is not mentally disordered under compulsory treatment while lengthy preparations are made for their release into the community; in most cases, release forthwith should occur on the day a person is found fit to be released.

¹⁰³ Rule 11(1)(g), Health Information Privacy Code.

¹⁰⁴ *Scott v Ministry of Transport* [1983] NZLR 234 at 236, Cooke J.

7.10 Reassessment following release from compulsory treatment order

The threshold for reassessing a former compulsory patient for a new term of compulsory treatment will vary depending on the history and circumstances of that person. A person with a long history of mental disorder with well-documented early warning signs of relapse may meet the compulsory assessment criteria as soon as those warning signs are detected. There is no need to wait for imminent danger to arise before reinitiating the procedures of the Act in such a case.¹⁰⁵ A recent release from compulsory status is not a bar to compulsory reassessment.

If a former compulsory patient is not previously known to a mental health service, or if the early warning signs of relapse are not well-defined, mental disorder may have to be more apparent before the procedures of the Act can be reinstated.

7.11 Extension to compulsory treatment order

A compulsory treatment order will expire after six months unless extended by a judge under section 34. If a responsible clinician thinks that it may be necessary to apply for an extension, they should perform a clinical assessment under section 76 of the Act within the last 14 days of a compulsory treatment order.

It is advisable that during this time the clinician consults with the family/whānau or whoever the patient's specified support network/person is. This reinforces the supported decision-making process by keeping the patient and their family fully informed about the decision to extend the compulsory treatment order (or not). As noted in section 5.5.2 above, the fact that an assessment under section 76 of the Act is a planned assessment, there is an expectation that the needs of the family/whānau will be taken into account to ensure their ability to participate. If this consultation does not occur, clinicians are expected to record the reasoning behind the lack of consultation.

Following this, the responsible clinician may then make an application for an extension to the order. Such an application must be lodged with the court before the close of business on the last day of the order. An application for extension is treated as if it is an application under section 14(4).

If granted, an extension will take effect from the date on which the order would otherwise have expired. Where an extension application has been lodged interim provisions allow compulsory treatment to continue under section 15 until the application is determined.

If an extension has been granted, statutory time periods requiring action within a certain time from the making of an order are not reset. For example, section 59(1) requires patients to accept treatment as directed by their responsible clinician within the first month of an order, without consent or a concurring second opinion, but this section does not apply following an extension. Similarly, the requirement under section

¹⁰⁵ *Re KMD* MHRT 04/139, 27 April 2005.

76(1)(a) to perform a clinical review within the first three months of an order does not apply following an extension.

8 Part 4: Special patients

The information in this part should be read alongside *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services* (Ministry of Health 2017).

There are five main categories of special patient defined in section 2 of the Act:

- persons found unfit to stand trial and made a special patient under section 24(2)(a) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CP(MIP) Act)
- persons found not guilty by reason of insanity and made a special patient under section 24(2)(a) of the CP(MIP) Act
- persons found guilty of a charge and both sentenced to a term of imprisonment and detained as a special patient under section 34(1)(a)(i) of the CP(MIP) Act
- remand or sentenced prisoners who require treatment for a mental disorder in a forensic facility under section 45 or 46 of the Act
- persons remanded for a court report, or pending trial or sentencing, under section 23, 35, 38(2)(c) or 44(1) of the CP(MIP) Act or section 184T(3) of the Summary Proceedings Act 1957.

8.1 Right to treatment

Special patients must be given the same care, treatment, training and occupation as they would be given if they were subject to a compulsory treatment order (section 44 of the MH(CAT) Act). This includes the right to ‘medical treatment and other health care (such as dental treatment, hearing aides, and glasses), appropriate to his or her condition’ (section 66 of the Act).

8.2 Non-consensual treatment

A special patient (other than a special patient admitted under section 46 of the Act, or detained in hospital under an order pursuant to section 23(2)(b), 35(2)(b) or 38(2)(c) of the CP(MIP) Act) is ‘required to accept such treatment for mental disorder as the responsible clinician shall direct’ ‘during the first month of the currency of the compulsory treatment order’ (section 59(1) of the MH(CAT) Act) and thereafter if a psychiatrist (not being the responsible clinician) appointed by the Mental Health Review Tribunal considers that the treatment is in the patient’s interests (section 59(2)(b)). In all other cases, a special patient’s written informed consent to treatment must be obtained (section 59(2)(a)), except in the case of emergency medical treatment if the patient is unable to consent, or if a prisoner is undergoing compulsory assessment and treatment as a special patient (see section 45(4) of the MH(CAT) Act). Consent is discussed in more depth at 10.2 below.

8.3 Special patients admitted under section 46

Special patients admitted under section 46 of the MH(CAT) Act may only be treated if informed consent has been obtained, like any other person admitted informally to hospital (see the Code of Rights, right 7(1)), except in the case of emergency medical treatment if the patient is unable to consent.

8.4 Special patients detained in hospital for inquiries or assessment under the Criminal Procedure (Mentally Impaired Persons) Act 2003

The information in this part should be read alongside the more detailed guidance provided in the *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services* (Ministry of Health 2017).

There are three short-term special patient orders that can be made under the CP(MIP) Act.

- An accused person in custody may be detained in hospital as a special patient pursuant to an order made under section 38(2)(c) for the purpose of a psychiatric examination during any stage of a criminal proceeding.
- After being found not guilty by reason of insanity, or unfit to stand trial, a person may be detained in a hospital as a special patient pursuant to an order made under section 23(2)(b) to determine the most suitable method of dealing with them.
- If a person is convicted, but appears to be suffering a mental impairment, they may also be detained in a hospital as a special patient under section 35(2)(b) to determine the most suitable method of dealing with them.

All of the special patients described above are subject to section 43(1) of the CP(MIP) Act. This provision declares that treatment may only be given to such patients with their consent. If consent is not forthcoming due to incapacity, the DAMHS may authorise any treatment ‘immediately necessary’ to prevent the serious mental or physical deterioration of the person, or serious suffering by the person, or the person causing harm to self or others (section 43(2)).

The intention of section 43 of the CP (MIP) Act is to prevent routine treatment without consent when a person’s legal status has not yet been finally determined through the criminal justice system. As such, this provision overrides the treatment provisions of the Mental Health Act. These CP (MIP) Act special patient orders are short-term in nature – sections 23 and 35 orders run for a maximum of 30 days, while section 38 orders may run for up to 14 days – but if a person is obviously mentally disordered and would benefit from compulsory treatment, there is no need to wait for the entire assessment or inquiry period to end before reporting to the court. If a person shows signs of serious deterioration or danger during this time, compulsory treatment is justified under section 43(2) of the CP (MIP) Act.

If a person is detained in a hospital on remand under section 44(1) of the CP (MIP) Act pending a hearing or trial, general provisions applying to the treatment of special patients apply (see 8.2 above and 10 below).

Despite section 43 of the CP (MIP) Act, however, if a person is detained in a hospital under section 23, 35 or 38 it is permissible to begin the process for compulsory assessment and treatment under the Mental Health Act (*KR v Capital and Coast DHB* HC Wellington CIV-2011-485-700 19 April 2011, at [24]). It is irrelevant that the person was first detained under the CP (MIP) Act.

It should be noted that under the Code of Rights ‘every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the patient is not competent’ (right 7(2)). The fact that a defendant is detained under a short-term special patient order does not, in itself, provide reasonable grounds for believing that they are not competent. Furthermore, the Code of Rights notes that an individual with diminished competence ‘retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence’ (right 7(3)).

8.5 Treatment of prisoners transferred from prison

8.5.1 Section 45

Compulsory treatment for mental disorder in prisoners can only occur within a hospital. If a clinician is considering discharging a person from hospital but considers that the person is unlikely to comply with treatment, a plan should be developed in consultation with the appropriate Corrections liaison to prevent repeated relapses and readmissions.

8.5.2 Section 46

Section 46 of the Act may be used to provide treatment for prisoners who would benefit from mental health treatment. This section requires the consent of the patient, and if appropriate may be used for those individuals who are not mentally disordered, but who would be particularly vulnerable if returned to prison.

A patient treated under section 46 may withdraw their consent. If this occurs, arrangements should be made to transfer the person back to prison as soon as is practicable (section 47(4)). However, if clinicians believe that such a person may be mentally disordered, the clinician should make arrangements for the superintendent of the prison from which the person was transferred to come to the hospital and see the patient with a view to making an application under section 45(2), unless the superintendent has seen the person within the last three days (as required by section 8A(c)).

8.5.3 Treatment while in prison

Treatment may be given to people in prison, with their informed consent. Effective liaison between forensic services and prisons will assist in encouraging patients to continue treatment after returning to prison and enable signs of deterioration to be detected and managed at an early stage. Right 4(5) of the Code of Rights requires cooperation among providers to ensure quality and continuity of services.

8.6 Section 47: Removal of certain special patients back to prison

Section 47 of the Act provides for the Director of Mental Health to approve the transfer back to prison of a patient who has been detained under section 45 of the Act. It also provides for the Director of Mental Health to direct that the patient be returned to prison under section 46 of the Act.

Section 47(3) of the Act notes that the prison concerned must make arrangements for the patient to be returned within seven days after the date on which the direction to transfer is given. It is rare for patients to be detained longer than a day after approval is received, but in such cases they may not be treated without informed consent (except in an emergency), but may be detained in hospital with the authorisation of the prison.

8.7 Leave from hospital

A special patient cannot go outside of a hospital mental health unit on leave without being granted leave by the Director of Mental Health or the Minister of Health.¹⁰⁶ Special patients are eligible to be granted leave once the criminal justice process relating to their detention has been finally determined.¹⁰⁷ Before leave can be granted, a special patient's clinicians and the Director of Mental Health will make a careful assessment of that patient's risk and balance this with the therapeutic value of leave before making a decision.

8.8 Victim notification requirements for special patients and other forensic patients

Victims of offences committed by special patients and other forensic patients may apply to be notified of certain changes to the treatment of those patients, including first unescorted leave from hospital and change of legal status. Further guidance around victim notification requirements can be found in the *Victim Notification Guidelines for Directors of Area Mental Health Services and DHB Victim Notification Co-ordinators* (Ministry of Health 2007) and section 11 of *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services* (Ministry of Health 2017).

¹⁰⁶ Sections 50 and 52 Mental Health Act.

¹⁰⁷ Section 50(2) Mental Health Act.

9 Part 4: Restricted patients

Sections 54 to 56 of the Act deal with the process and effect of a restricted patient order.

Restricted patient status may be imposed on an inpatient who ‘presents special difficulties because of the danger he or she poses to others’ following an application by the Director of Mental Health to the District Court. Such patients must be subject to an inpatient order. Restricted patients need not have entered the mental health services by way of the criminal justice system, but many such patients will have a long history of contact with forensic services and may have previously been detained as special patients. Restricted patients will be managed by a Regional Forensic Psychiatry Service.

The management of restricted patients is similar to that of special patients. That is, they are not permitted leave without the approval of the Director of Mental Health or the Minister of Health, and the patient cannot be released from restricted patient status solely by their responsible clinician. Because such a high level of restriction is placed on such patients, the reasons for applying for such an order need to be very clear.

Restricted patient orders are a rare and severe limitation on a patient’s rights. If clinicians have concerns that an inpatient in their care may present special difficulties so that management under an inpatient treatment order is not possible, they should discuss the case with their DAMHS. The DAMHS can then refer the case to the Director of Mental Health if appropriate.

Further information regarding restricted patients can be found in sections 8 and 9 of *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services* (Ministry of Health 2017).

10 Part 5: Compulsory treatment

10.1 Consensual and non-consensual treatment

All consumers of health and disability services have the right to make an informed choice and give informed consent (Right 7, Code of Rights). The presence of a serious mental health condition does not in itself mean a person has lost the capacity to make an informed choice.

People with a serious mental health condition can retain capacity in relation to a range of decisions, including decisions about their treatment. Where a consumer has diminished decision-making capacity, they still retain the right to make informed decisions and give informed consent, to the extent appropriate to his or her level of competence (Right 7(3), Code of Rights).

A compulsory patient is ‘required to accept such treatment for mental disorder as the responsible clinician shall direct’ during the first month that the compulsory treatment order is current (section 59(1)).¹⁰⁸ After the first month of an order, if a patient does not consent to treatment compulsory treatment can still be given if a psychiatrist (not being the responsible clinician) appointed by the MHRT considers that the treatment is in the patient’s interests (section 59(2)(b)).¹⁰⁹

Despite the use of compulsion, clinicians must make efforts to obtain a patient’s consent to treatment whenever possible. In all cases except emergency treatment, a clinician must attempt to obtain a patient’s written consent to treatment (section 59(2)(a)) which may be withdrawn at any time (section 63).

10.1.1 Consent under the Mental Health Act¹¹⁰

‘Consent’ as used in section 59(2)(a) is not the same concept as ‘informed consent’ that is understood by clinicians generally. Informed consent should be obtained in the absence of coercion, whereas consent to compulsory treatment necessarily requires some degree of coercion to have already been used. In this case, the patient whose consent is sought is already subject to a compulsory treatment order, and the refusal of consent will not normally bring a compulsory treatment order to an end.

‘Consent’ in this context therefore refers to both informed consent and the lesser ‘assent’, which may be influenced by an element of coercion. The Medical Council of

¹⁰⁸ Note that an extension to a compulsory treatment order will not restart the requirement for a patient to accept treatment within the first month of an order under section 59(1) (see 6.11).

¹⁰⁹ Except in the case of electroconvulsive treatment and brain surgery.

¹¹⁰ For further analysis see Skipworth J. 2011. *Capacity to consent to treatment in forensic mental health care*. PhD thesis: University of Otago.

New Zealand describes informed consent as an interactive process between a doctor and patient to help the patient gain an understanding of their condition and make an informed decision about their care, including any expected risks, side effects, benefits and costs to the patient (if any) of each option.¹¹¹ Clinicians seeking a patient’s consent for treatment under the Mental Health Act should strive to meet the standard of *informed* consent to the greatest extent possible within the framework of the Act.

Clinicians will experience significant difficulty in determining the extent to which a person’s consent is influenced by coercion. To mitigate this, clinicians should offer all patients the choice of receiving a second opinion under section 59(2)(b). Clinicians should also remind patients of their right to seek independent psychiatric advice under section 69 with a psychiatrist of their choice.

In order for any consent to be valid, the patient must have the capacity to consent to the proposed treatment (right 7(2), Code of Rights). The principles and practical guidance surrounding the seeking of informed consent are recognised and described in the RANZCP Code of Ethics (see Principle 5). A patient will have capacity to consent if they are able to:

- understand the information relevant to the decision (see section 11.4 below)
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate their decision (by any means).

It should not be assumed that a patient who passively acquiesces is competent to consent. It is also important to recognise that capacity to provide consent may fluctuate, so that an incompetent patient may regain capacity during a course of treatment. A return of capacity to consent to treatment, or a withdrawal of consent to at any stage, should lead to a re-evaluation of the legal basis of any further treatment.

Assessment of decision-making capacity is recognised as a vital skill for clinicians, with important human rights implications.¹¹² Capacity relates to the decision that must be made – for example, someone may have capacity to make a decision about one aspect of their health care, but not another. Decision-making capacity does not relate to whether a person is likely to make a “good” choice- that is, people are entitled to make decisions that other people would consider unwise or foolish (‘dignity of risk’).

If a patient lacks capacity to consent to treatment for mental disorder, the approval of a psychiatrist appointed by the MHRT must be obtained under section 59(2)(b) of the Act, and family or whānau should be consulted under section 7A(2). A second opinion must also be obtained when a patient with capacity refuses consent, and when a patient indicates that they want a second opinion.

¹¹¹ https://www.menz.org.nz/assets/MediaReleases/f74334fa3c/2019-Review_Appendix-1_Draft-informed-consent-statement.pdf

¹¹² Ryan, C., Callaghan, S., & Peisah, C. (2015). The capacity to refuse psychiatric treatment: A guide to the law for clinicians and tribunal members. *Australian & New Zealand Journal of Psychiatry*, 49(4), 324-333.

If a patient does not give written consent to treatment or a second opinion for treatment, any treatment that is administered that is not provided under the provisions of urgent treatment (section 62) (see section 10.2 below), may be considered as an assault to the patient.

Clinicians are required to regularly discuss treatment options with compulsory patients (see section 11.4 below). A responsible clinician should regularly make efforts to gain a patient's consent to treatment after thoroughly discussing the available treatment options with the patient. Compulsory treatment reliant upon a second opinion should be a last resort (see section 10.1.2 below). A second opinion will only persist for a reasonable period of time while a compulsory patient's mental state and treatment remains consistent with the scope of the opinion, and in any case for no longer than one year.

10.1.2 Second opinions

In the event a patient does not consent to continued treatment after the first month under section 59(2)(a) of the Act, in order to continue treatment section 59(2)(b) requires a determination that the treatment is in the interest of the patient by a psychiatrist, who is not the responsible clinician, who has been appointed for this purpose by the MHRT. In other words, a second opinion is required. This is also required with respect to the administration of electro-convulsive treatment when a patient does not consent under section 60 of the Act.

Second opinions are recognised as a way to improve the quality of mental health care, and to reduce the overall costs to individuals and society.¹¹³ Second opinions can help people learn more about their mental health condition, treatment and possible alternative treatments, and may provide people with some additional information to support their participation in treatment decisions.¹¹⁴

An approved psychiatrist providing a second opinion under section 59(2)(b) or section 60(b) of the Act must certify that the proposed treatment is in the 'interests' of the patient. 'Interests' does not simply mean one of many accepted treatments for the condition which causes no harm. A psychiatrist providing a second opinion under section 59 or section 60 is required to do more than merely assess whether, for example, schizophrenia is normally treated with an antipsychotic; the test of the patient's interests is influenced by other legal requirements.

A psychiatrist providing a second opinion should:

- consider the patient's history, including the course of the illness and prior pharmaceutical regimes
- assess the relative risks and benefits of the range of potential treatment approaches

¹¹³ Heuss, S. C., Schwartz, B. J., & Schneeberger, A. R. (2018). Second Opinions in Psychiatry: A Review. *Journal of psychiatric practice*, 24(6), 434.

¹¹⁴ Second Psychiatric Opinion Service, Victoria, Australia
<https://www.secondopinion.org.au/about-us/>

- consider the patient’s views as far as they can be ascertained, by engaging with the patient where reasonably possible this may be accomplished through supported decision-making (see section 1.3 above)
- take into account any previously expressed wishes/preferences of the person and/or talk to family/whanau if appropriate
- consider whether the treatment is the least restrictive alternative and proportionate to the assessed risks under the New Zealand Bill of Rights Act 1990 (NZBORA) and the Code of Rights
- consider whether the treatment is of maximal benefit to the patient and appropriate to the patient’s condition (section 66 of the Act)
- consider whether the treatment is necessary to achieve the purpose of compulsory intervention.

Dawson et al¹¹⁵ suggest that the psychiatrist providing a second opinion “should make an informed decision, based on the evidence, for which a reasonable justification can be given”. This will usually require study of the patient’s files and communication with the responsible clinician (and possibly other members of the treating team).

The second opinion psychiatrist should only endorse the current treatment if that treatment appears to be appropriate and/or efficacious. As opinions on best practice with regards to a certain patient’s condition are likely to vary between clinicians, it will be sufficient for second opinion psychiatrists to endorse any good practice treatment and then, if appropriate, suggest alternatives which must then be considered by the responsible clinician.

If a second opinion psychiatrist does not agree that the proposed treatment represents best practice in light of all the circumstances, the responsible clinician should ask the DAMHS to help resolve the disagreement. There are several steps a DAMHS could take in this situation:

- mediate a discussion between the responsible clinician and the second opinion psychiatrist to try and develop a best practice solution both can agree on
- direct that another approved psychiatrist provide a further second opinion
- if the DAMHS is an approved psychiatrist, provide a second opinion.

In order to reduce the possibility of actual and/or perceived bias, the second opinion psychiatrist should ideally not work in the same DHB or facility. It is not acceptable for the second opinion psychiatrist to be in the same team as the responsible clinician. It will not be appropriate for the responsible clinician to select an approved psychiatrist based on the likelihood that their second opinion will agree with the proposed treatment.

¹¹⁵ Dawson, J., Ellis, P., Glue, P., Lenagh-Glue, J., Goldsmith, D., Smith, D. A., & Gledhill, K. (2013). Mandatory second opinions on compulsory treatment. *New Zealand’s Mental Health Act in Practice* (ed J Dawson and K Gledhill), 229-46.

10.1.3 Recording of second opinion processes

Section 59 and 60 second opinions must be adequately recorded in the patient's files. At a minimum the information recorded should include:¹¹⁶

- Dates that the second opinion was requested and completed
- The second opinion psychiatrist's name and the date of assessment
- Patient demographic and clinical information, including: diagnosis, history, prior and current treatment, past response to requested treatment and any side-effects experienced
- Any discussions with and preferences expressed by the patient, including any prior competently expressed wishes (for example, in the form of an advance directive)
- Discussions with family/whānau, the treating team and any legal representation
- Relative risks and benefits of the proposed treatment or alternatives
- Evaluation of capacity to consent
- Any other relevant observations or comments, including reference to additional notes in the patient's files.

10.2 Non-consensual emergency treatment

The law permits medical treatment to be administered in an emergency to any person who is unable to consent to such treatment. This exception is recognised by Right 7(1) of the Code of Rights. It applies to patients subject to a compulsory treatment order as it does to any other patient. Furthermore, section 62 of the Act effectively preserves the legal right to administer any treatment that is 'immediately necessary to save the patient's life, to prevent serious damage to the health of the patient, or to prevent the patient from causing serious injury to himself or herself or others'.

10.3 Electroconvulsive treatment

The special provisions relating to electroconvulsive treatment (ECT) are contained in section 60 of the Act. The Act provides two procedures by which ECT may be administered:

- the patient consents in writing to the treatment (section 60(a))
- a second opinion psychiatrist agrees that the treatment is in the patient's interests (section 60(b)).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) publication *Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy*¹¹⁷ should be taken into account whenever ECT is considered.

¹¹⁶ Dawson, J., Ellis, P., Glue, P., Lenagh-Glue, J., Goldsmith, D., Smith, D. A., & Gledhill, K. (2013). Mandatory second opinions on compulsory treatment. *New Zealand's Mental Health Act in Practice* (ed J Dawson and K Gledhill), 229-46.

¹¹⁷ Weiss, A., Hussain, S., Ng, B., Sarma, S., Tiller, J., Waite, S., & Loo, C. (2019). Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy. *Australian & New Zealand Journal of Psychiatry*, 0004867419839139.

Further information for consumers and their families is contained in the Ministry of Health publication *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know* (Ministry of Health June 2009).

10.3.1 Electroconvulsive treatment with consent

The primary procedure contemplated by the Act is ECT with patient consent (section 60(a)). A responsible clinician should always attempt to gain a patient's agreement to ECT by fully explaining the expected benefits and side-effects in accordance with section 67 (see section 11.4 below).

In order for any consent to be valid, the consenting patient must have the capacity to consent to ECT. See section 10.1.1 above for a discussion on consent under the Mental Health Act. The RANZCP notes that, in relation to seeking informed consent from patients considering ECT:

- Enough information should be provided for patients to make an informed decision. It is recommended that families and caregivers are involved in this process where possible. Adequate time should be made available for patients and their families and caregivers to discuss any concerns.
- During the consent process, patients should be given information on the potential side effects of ECT, particularly the possible loss of short term and recent memories around the time of ECT, and occasionally, past memories. The practitioner should take into account the patient's mental state in deciding on the level of detail given. Family and carers may also be involved in this process.¹¹⁸

Because a clinician cannot easily measure the impact of coercion on a patient's decision, the clinician should always offer the patient a non-prejudicial second opinion under section 60(b) (see 10.1.2 above).

It is essential to provide adequate information to a patient for whom ECT is proposed (see section 11.4 below).

Because mental illness can affect capacity, it is desirable for compulsory patients to express views about the acceptability of possible future treatment options, including ECT, at a time when they have capacity to consider those options. If patients who have recorded competently expressed views on ECT lose their capacity to consent, those views must be considered by responsible clinicians and by psychiatrists providing second opinions under section 60 of the Act. Section 5 of the Act requires that clinicians exercise powers conferred on them with proper respect for the person's cultural identity and personal beliefs. It is important to note that section 67 of the Act states that a patient is entitled to receive an explanation of the expected effects of any treatment, including the expected benefits and likely side effects.

¹¹⁸ RANZCP. March 2014. *Electroconvulsive Therapy (ECT) – Position statement 74*.
[https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/electroconvulsive-therapy-\(ect\)](https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/electroconvulsive-therapy-(ect))

10.3.2 Electroconvulsive treatment with second opinion

ECT can also be administered in circumstances where the patient is either not competent to consent, or refuses to consent, so long as the treatment is considered to be in the interests of the patient by a second psychiatrist, approved by the MHRT, who practises independently of the requesting clinical team (section 60(b)). Although this potentially allows a patient's competent refusal to be overridden by what is considered to be in the interests of the patient, good clinical practice will dictate that this only occurs in exceptional circumstances.¹¹⁹

The Ministry recommends that a second opinion should apply only to one course of ECT treatments. Clinicians should attempt to obtain consent for each new course of treatment. In the case of an acute treatment course, it is recommended that consent be reviewed and renewed after approximately 12 treatments. In the case of maintenance (continuation) ECT, it is recommended that patients renew their written consent at regular intervals, such as every six months or every 12 treatments.

¹¹⁹ See Principle 5 of RANZCP. 2018. *Code of Ethics*.

11 Part 6: Rights of patients and proposed patients

Sections 64 to 75 of the Act set out the rights of patients subject to the Act. Proposed patients have the same rights as patients (see 11.12 below) except the right to receive and send letters and postal articles (sections 73 and 74 of the Act). This is because the short duration spent as a proposed patient (usually a few hours) makes those rights unnecessary.

The rights in sections 64 to 75 of the Act supplement the rights affirmed in the NZBORA and the rights enjoyed by all health service consumers under the Code of Rights (this includes patients and proposed patients under the Act). The powers for providing compulsory assessment and treatment under the Act should be read consistently with the rights in the NZBORA and the Code of Rights as far as possible. It is important to remember that the rights of patients and proposed patients under the Act are enforceable through the complaints mechanism under section 75 of the Act.

Taking a supported decision-making approach will help clinicians apply the powers of the Act in a way that respects the rights of patients and proposed patients. See section 1 above for a discussion on taking a human rights approach to the application of the Mental Health Act.

11.1 Section 64: General rights to information

In addition to receiving information about proposed treatment (see 11.4 below), at the time of becoming a patient (section 64(1)), patients must be given a written statement of their rights as a patient under the Act and must be kept informed of their changing status and review and appeal rights (section 64(2)). Note that section 23(1)(a) of the NZBORA states that ‘everyone ... who is detained under any enactment ... shall be informed at the time of the ... detention of the reason for it’. This right to information extends to proposed patients.

There is a collection of ‘Your Rights’ documents on the Ministry of Health website. These are translated into: Te Reo Māori, Samoan, Simplified Chinese, Tongan, Hindi, Northern Chinese (Mandarin), French, Yue (Cantonese), Sinitic (Sino-Tibetan), German, Punjabi, Arabic, New Zealand Sign Language, and English.

A person may become ‘detained’ for the purposes of section 23(1) of the NZBORA before becoming a proposed patient if the situation is urgent and section 38 procedures are adopted.¹²⁰ If the person is urgently detained under section 38, the DAO should if possible inform the person of the reason for their detention, their right to consult a lawyer and the right to have the validity of their detention determined by a court. This

¹²⁰ *Sestan v DAMHS, Waitemata DHB* [2007] 1 NZLR 767.

may be done by providing a written statement of those rights. It is good practice for DHBs to include a detained person's rights under section 23(1) NZBORA in the statement of rights required to be supplied under section 64(1).

When a patient is not included in a meeting with the clinical team and whānau, the patient should receive feedback about what was discussed after the meeting. Clinical teams should also provide contact details for the Health and Disability Commission advocacy service. Health and Disability Commission advocates can be very helpful to patients and can complement the services provided by District Inspectors.

General rights to information should include how leave from the Act is decided and how leave is cancelled, for example that it should be in writing. This is a very important matter for detained patients.

Clinical teams should always consider emailing information rather than relying on the postal services, (this is particularly important when a patient is in the community).

11.2 Section 65: Respect for cultural identity

Section 65 of the Act affirms that 'every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5'. This requirement is reinforced by Right 1(3) of the Code of Health and Disability Services Consumers' Rights (the Code of Rights), and section 15 of NZBORA states that every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private. As a basic patient right the entitlement to be dealt with in a culturally appropriate manner becomes enforceable through the complaints procedures set out in section 75.

Respect for cultural identity includes enabling a patient to communicate in their language of choice, wherever practicable, and respecting cultural concepts such as those related to the body or to the appropriateness of interactions with male or female staff. It should be noted that mental health and addictions services should ensure interpreters are available for all patients where possible. See section 4.2 above for more information about interpreters, and communicating with proposed patients and patients where English is not a first language. For more in depth discussion about culturally appropriate care refer to chapter 4 above.

11.3 Section 66: Right to treatment

'Every patient is entitled to medical treatment and health care appropriate to his or her condition.' Treatment should be holistic and seek to address the range of factors that impact on a person's condition (e.g., trauma, substance use, cultural). This requires multidisciplinary care, which is consistent with the recovery approach to mental health, and may be facilitated through supported decision-making (see section 1.3 above).

Substantive treatment which takes proper account of a patient's cultural identity and personal beliefs (section 5 and 65 of the Act) is an inherent component of the right of a patient to medical treatment and health care appropriate to his or her condition.

If the person is an inpatient, they are entitled to be offered the same level of treatment and care that would be available to any other hospital patient, for health conditions not related to the mental disorder. This may include facilitating treatment for dentistry, hearing aides, and glasses.

11.4 Section 67: Right to be informed about treatment

Before starting any treatment, patients are entitled to receive ‘an explanation of the expected effects of any treatment ... including the expected benefits and the likely side-effects’ (section 67). 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), Code of Rights).

The quantity and quality of the information given will depend on the nature of the situation. In an emergency situation when it is necessary to treat a patient without their consent, a very limited explanation of what is happening will be sufficient. At all other times that treatment is given, the information provided should be comprehensive. Because clinicians should always try to seek the consent of patients, it is important that clinicians attempt to give a patient enough information as would allow a reasonable person to make an informed decision. This information should include:

- details of the drug, dose and method of administration proposed (if a proposed treatment is pharmaceutical)
- the likely course of the treatment
- the intended effects of the treatment on the mental state of the patient
- the possible side effects of the treatment
- any other relevant information.

The right to be informed is an important part of the consent process discussed in section 10.1.1 above. Poor information will not allow the patient to make an informed decision, and may lead to judicial review.¹²¹

Patients are entitled to effective communication in a form, language and manner that enables them to understand the information provided, and in an environment that enables open, honest and effective communication (right 5, Code of Rights). It is essential that the information about the treatment be comprehensive. Consideration should always be given to the patient’s present mental state, and information should be repeated as appropriate if that state alters. Information communicated in written form should also be explained verbally. Under right 6(4) of the Code of Rights, ‘every consumer has the right to receive, on request, a written summary of information provided’.

¹²¹ *JE v Capital and Coast DHB* HC Wellington CIV-2009-485-1106, 19 June 2009.

Patients 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.

Clinical teams should inform patients and their family/whānau that District Inspectors are available to support them in their understanding of the legal rights and obligations available under the Act.

11.5 Section 68: Further rights in case of visual or audio recording

Section 68(1) of the Act states that every patient is entitled to be informed where it is intended to make or use a videotape or other visual or audio recording of any interview with, or any other part of the treatment of, the patient. Section 68(2) states that no subsection (1) recording shall be done without the prior consent of the patient or their personal representative.

With respect to the use of closed-circuit television (CCTV), the environment of clinics and hospitals inherently exhibits daily treatment. CCTV may at times, and in certain settings, be appropriate and necessary to monitor for the safety of patients, staff, and any person within the hospital. Because section 68 specifies that a patient's informed consent is required if the intention is to make or use a videotape (or other visual or audio recording), this will not include the live monitoring of CCTV. That is, if the CCTV footage is only monitored in real-time (and is not recorded and kept), this does not meet the requirements where for which patients must provide informed consent. If CCTV footage were to require informed consent from patients, refusals under section 68 means that a hospital/clinic would not be able to operate a CCTV system.

Note that rule 4 of the Health Information Privacy Code provides that health information must not be collected by a health agency by unlawful means or by means that are unfair or which intrude to an unreasonable extent upon the personal affairs of the individual concerned. Visual or audio recording of a patient contrary to section 68 of the Act would likely also be contrary to rule 4 and may entitle the patient to complain under the Privacy Act.

11.6 Section 69: Right to independent psychiatric advice

The personnel who undertake the statutory assessment procedures are appointed by the DAMHS. If exercised, the right to independent psychiatric advice entails an additional process that will usually occur only in a non-urgent situation. 'Independent' means independent of the process of treatment of the patient. It does not mean that a psychiatrist who is employed by another service will necessarily be provided. However, the Act states that the patient is entitled to seek consultation with 'a psychiatrist of his or her own choice'. Thus, if the named psychiatrist of the patient's choice is from another service, the consultation should be facilitated by the staff responsible for the patient's care and treatment. Advice from psychiatrists not employed by the DHB in which the patient receives treatment may incur costs that will be borne by the patient.

11.7 Section 70: Right to legal advice

Services should ensure that patients and their family/whānau are aware of, or have the contact details of, district inspectors available in their area. Where a patient requires alternative legal advice, services should ensure that satisfactory arrangements have been made with the local branch of the New Zealand Law Society to ensure that a patient or proposed patient can obtain the services of a lawyer if they do not already have a lawyer. This can be facilitated by obtaining from the Law Society a list of names of counsel suitably experienced and trained to give legal advice under section 70 of the Act.

If a patient or proposed patient asks to see a named lawyer, that person should be contacted. Note that under section 23(1)(b) of the NZBORA ‘everyone ... who is detained under any enactment ... shall have the right to consult and instruct a lawyer without delay and to be informed of that right’. This right to legal advice extends to proposed patients.

11.8 Section 71: Right to company, and seclusion

Section 71 provides that every patient is entitled to the company of others. In practice, this right is applied in inpatient units to ensure that patients are not isolated without cause. There is no enforceable right for treating clinicians to ensure that a patient enjoys company in the community, but in some situations it may be appropriate for clinicians to take steps to promote social and family contact.

The goal of reducing and eventually eliminating seclusion in mental health services was introduced in 2012.¹²² Since the creation of the Mental Health Act attitudes to the use of restrictive practices have evolved. It is now generally recognised that seclusion has no therapeutic value. Research shows that seclusion and restraint can damage relationships and traumatise both the person and staff involved (Te Pou o te Whakaaro Nui 2018). Our data tells us that nationally Māori and Pacific peoples are much more likely to be secluded than others. This requires an emphasis by inpatient services on reducing seclusion rates for Māori and Pacific peoples and is linked to providing culturally responsive services (refer section 4 of this document).

In rare cases it may become necessary for a patient or a proposed patient to be secluded for their own safety or the safety of others. In such cases, section 71 of the Act should be observed and the procedures set out in the publication *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health February 2010) and the *Health And Disability Services (Restraint Minimisation and Safe Practice) Standards* (NZS 8134.2:2008) should be adhered to. Assessment of a proposed patient should be conducted as a matter of urgency in such circumstances. No more force than is necessary should be used to seclude a person.

¹²² Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health.

11.9 Section 72: Right to receive visitors and make telephone calls

This section equally applies to proposed patients or patients. In some cases a proposed patient may wish to advise others of their compulsory assessment under the Act and to make personal arrangements. If it is safe to do so, the proposed patient should be given access to a telephone. Depending on the nature of the inpatient unit and potential risks, it may be appropriate to seize a person's personal mobile phone (see 11.13.1 below). However, it should be considered that removing a person's mobile phone may also remove access to a range of digital communication such as email, social media platforms and the internet, which has an impact on the following rights under sections 73 and 74. It is important to exercise some flexibility in this decision and it is the responsible clinician who needs to be making a clinical judgement about whether phones should be taken away from a patient.

Further, consideration should be given regarding patient access to video calls or conferencing options, particularly if such access facilitates required family/whānau consultation under section 7A of the Act, or enables a patient to achieve and maintain family/whānau connectedness as part of their cultural, ethnic, language, or religious identity per sections 5 and 65 of the Act.

11.10 Sections 73 and 74: Right to receive/send letters and postal articles

The rights to send and receive letters and postal articles are limited by sections 123 and 124 of the Act when a person is undergoing compulsory assessment or inpatient treatment in a hospital. Correspondence not in the interests of the patient to send or receive may be withheld by the responsible clinician, unless the correspondence is to or from an official or legal or medical professional as specified in section 123(3). If a person has notified a hospital that they do not wish to receive communications from a patient, such correspondence may be withheld. These sections do not apply to proposed patients because of the short duration of the assessment period.

The Act does not consider the monitoring of electronic communications such as emails and text messages. The Ministry of Health considers that there is no requirement for inpatient facilities to supply computers or cell phones for patient use, but such amenities may be appropriate in certain facilities and it is important to respect a patient's freedom of expression (including the right to correspond via electronic means). If patients have access to such devices, responsible clinicians have the same powers to examine and withhold correspondence as if the communications were letters, but may not withhold letters to or from the people specified in section 123(3).

Withheld correspondence must be laid before a district inspector under section 125.

11.11 Section 75: Complaint about a breach of rights

Section 75 of the Act gives district inspectors jurisdiction to investigate complaints of breaches of the rights of patients under sections 64 to 74 of the Act (and proposed patients under section 63A).

All consumers of health and disability services may make complaints to the Health and Disability Commissioner regarding breaches of rights affirmed in the Code of Rights. Each region has a Health and Disability Services consumer advocate available to assist consumers in making complaints regarding a breach of their rights (section 30 of the Health and Disability Commissioner Act 1994).

Parliament has appointed an Independent Police Conduct Authority (IPCA) to investigate allegations of misconduct or neglect of duty by Police. The IPCA has primary jurisdiction in that area.

For further information, refer to the *Guidelines for the Role and Function of District Inspectors* (Ministry of Health February 2012).

11.12 Rights of proposed patients

Section 2A of the Act provides a definition of ‘proposed patient’. Section 63A describes the rights of proposed patients. A person becomes a proposed patient when an application is ‘made’ under section 8A of the Act. An application is ‘made’ when both the application under section 8A of the Act and the certificate under section 8B of the Act are completed and received by the DAMHS. The rights of proposed patients pursuant to section 63A do not apply during the health practitioner, nurse practitioner or registered nurse working in mental health’s assessment of the person under section 8B, or during the applicant’s contact with the person.

Proposed patient status ends when a health practitioner either:

- records a finding under section 10(1)(b)(i) of the Act, in which case the person does not become a patient, or
- records a finding under section 10(1)(b)(ii) of the Act, in which case the person becomes a patient.

A person should normally be a proposed patient for only a matter of hours. It is important that a written statement of rights is given to the proposed patient in conjunction with a section 9 notice. A proposed patient may exercise any right under the Act, but only to the extent that the compulsory assessment process is not unreasonably affected. The arrangements for a proposed patient’s assessment examination, and the conditions and venue of a patient’s detention, should not be unreasonably affected by any section in part 6 of the Act.

11.13 Rights under the New Zealand Bill of Rights Act 1990

Many rights under the New Zealand Bill of Rights Act 1990 (NZBORA) are relevant to the compulsory assessment and treatment process. Mental health service staff should take NZBORA into account when making decisions under the Act. The relationship between NZBORA and the Mental Health Act is discussed in more detail in section 1.2.1 and requires those applying the Act to use the least restrictive approach possible. These guidelines highlight several areas of potential concern below.

11.13.1 Unreasonable search and seizure

Mental health services have a duty of care to provide safe and appropriate services of a reasonable standard¹²³ and to protect vulnerable consumers in their care from injury,¹²⁴ and to take all practicable steps to ensure the safety of their employees.¹²⁵ Normally a power to search a person and/or seize their property must be specified in statute. No such power is specified in the MH(CAT) Act, but the Ministry considers that such a power is necessarily implied for the effective and safe provision of compulsory mental health care.

Section 21 of the New Zealand Bill of Rights Act 1990 (the NZBORA) requires that a search and seizure policy is reasonable, and that each particular act of searching for or seizing property must also be reasonable. To comply with section 21, inpatient units should develop search and seizure policies that provide for reasonable searches that:

- are non-arbitrary (for example, indicated by a structured and rational assessment)
- are rationally connected to the risk a person is thought to pose to self or others
- are proportional to the risk a person is thought to pose to self or others and only infringe rights and freedoms to the extent necessary to address that risk
- do not unduly diminish a person's dignity or invade their reasonable expectation of privacy.

In most situations a search may only be undertaken based on these principles. In determining whether a search and seizure policy or a particular instance of search or seizure is reasonable, the clinician or staff member should consider the principles above in the context of the:

- nature of the facility or ward
- level of compulsion the person is subject to
- seriousness of the potential harm to the person and to others
- imminence of the potential harm
- likelihood of the potential harm

¹²³ See for example right 4 of the Code of Health and Disability Consumers' Rights; section 66 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

¹²⁴ Section 151 of the Crimes Act 1961.

¹²⁵ Section 6 of the Health and Safety in Employment Act 1992; section 22(1)(k) of the New Zealand Public Health and Disability Act 2000.

- factors particular to a person.

Rational processes for search and seizure should always include:

- searches and seizures being carried out by appropriately experienced and trained staff
- adequate record-keeping, including a list of the items removed and giving a copy of the list to the owner of the property
- retention of property for only as long as necessary to achieve the purpose for which it was removed
- review of instances of search and seizure by management
- appropriate storage or disposal of property.

Clinicians should endeavour to discuss search and seizure policies with a person shortly after their admission. Any search and seizure procedure should also include opportunities and encouragement for patients to voluntarily hand over dangerous items, and attempts to gain the person's consent to a search whenever possible. Compulsory patients have a right to receive visitors under section 72, but it may be reasonable to exclude visitors or make visitors subject to searches if clinicians have reason to believe that a friend or relative of the patient is bringing dangerous or disruptive items onto an inpatient unit.

In some situations a search will be explicitly permitted by statute. For example, a personal search may be reasonable in the following situations.

- A senior clinician has reason to believe that an inpatient is in possession of controlled drugs. The clinician may ask the person to voluntarily hand over any controlled drugs, and a search may be carried out under a policy developed in line with the principles described above. However, if an intrusive or internal search becomes necessary, the clinician should not perform the search but may refer the matter to a member of the Police under section 18 of the Misuse of Drugs Act 1975.
- A person has reason to believe that a person is in the possession of a weapon or dangerous substance that the person is going to use to attempt to commit suicide or to commit an offence that could cause immediate and serious injury to any person or property. In such cases, characterised by extreme urgency and serious consequences, a personal search may be justified under s 41 of the Crimes Act 1961.

11.13.2 Proper process for detention under the Act

Section 22 of the NZBORA provides that a person has the right not to be arbitrarily detained. This means that a DAO or a member of the Police exercising a power to take and detain a person should only act according to a fair and consistent process based on the risk that a person poses to self or others.

Section 23(1) of the NZBORA requires the person detaining someone under the Act to inform them of the reason for their detention, their right to consult and instruct a lawyer, and the right to have the validity of their detention challenged in a court. These rights should be contained in the statement of rights given to a patient or proposed patient under section 64(1) of the Act.

11.13.3 Right to refuse medical treatment

Section 11 of the NZBORA provides that everyone has the right to refuse to undergo medical treatment. The Act provides an exception to that right, based on the potential harm of not providing compulsory treatment. It is therefore important that compulsory treatment is delivered in a way that complies with statutory requirements, respects a person's rights, promotes recovery and protects or enhances their dignity or mana.

Section 23(5) of the NZBORA provides that everyone deprived of their liberty (including under the Mental Health Act) shall be treated with humanity and with respect for the inherent dignity of the person. Moreover, under section 114 of the Mental Health Act it is an offence punishable by imprisonment to intentionally ill-treat or intentionally neglect a proposed patient in carrying out the assessment of a proposed patient or the assessment and treatment of a patient under the Act.

12 Part 7: Reviews and judicial enquiries

The clinical and judicial review process differs depending on the nature of a patient's treatment order. The review process for different types of treatment orders are outlined in Figures 3 to 6.

12.1 Duty to conduct clinical review of patients

All compulsory patients must be formally reviewed by the responsible clinician under section 76, 77 or 78 of the Act, depending on the type of order the patient is subject to. The first clinical review must occur within the first three months of the court order allowing compulsory treatment.¹²⁶ Subsequent clinical reviews must occur within six months of the previous review. Note that the duty to review a patient's condition regularly does not end when a compulsory treatment order is of indefinite duration.

A clinical review carried out under section 76, 77 or 78 of the Act must be solely for the purposes of that section not for the purposes of any other section under the Act, for example to gain a second opinion to allow compulsory treatment under section 59(2). Conducting a review to fulfil multiple purposes may be prejudicial to the patient, and is a breach of the principle of natural justice. For example, a patient may be more likely to consent to treatment under section 59(2)(a) if a concurrent review under section 76 could result in their immediate release.

If a responsible clinician does not review a compulsory patient within the time period provided by section 76, 77 or 78 of the Act, a district inspector may apply to the MHRT for a review of the patient's condition to ensure that a timely review occurs.

The clinical review should be a rigorous, holistic assessment of the person's condition, which considers the range of factors relevant to a person's condition (e.g. family and whanau, substance use/addiction, least restrictive options).

12.2 Applications to the Mental Health Review Tribunal

After a certificate of clinical review has been completed, any person to whom the certificate was sent may apply to the MHRT for a review of the patient's condition. An

¹²⁶ It is not necessary to perform a clinical review within the first three months of an extended compulsory treatment order (see section 7.11 above).

application can be facilitated through a district inspector. In all cases, permitted applicants to the MHRT under section 76(7)(b) will include:

- the patient
- the patient's welfare guardian (if applicable)
- the patient's principal caregiver
- the patient's primary health care provider
- a district inspector.

If a clinical review has been carried out on a special patient found not guilty on account of insanity, or unfit to stand trial, the Director of Mental Health may also apply to the MHRT (sections 77(3)(b)(ii), 77(4)(b)(ii)). If a clinical review recommends release from compulsory status for a restricted patient, the Director of Mental Health may also apply to the MHRT (section 78(5)(b)). The Attorney-General and Minister of Health may also refer cases to the MHRT in certain situations under sections 77 and 78.

The MHRT may also review a patient's condition on its own motion (section 79(2)). Regardless of whether a patient has received a certificate for clinical review, there is no limitation on them communicating with the Convenor of the MHRT and requesting a review. There is no obligation for the MHRT to act on such a request.

12.3 Mental Health Review Tribunal reviews of patients

Following a clinical review, a person who has received a copy of the certificate of review (see 12.2 above) may apply to the MHRT under section 79, 80 or 81 of the Act, depending on the type of order the patient is subject to. The MHRT's statutory procedure is set out in Schedule 1 to the Act.

The MHRT's jurisdiction is limited to a consideration of whether a patient remains mentally disordered (see 2.1 above). The MHRT cannot make recommendations as to the appropriateness of a patient's treatment; such concerns should be addressed to a district inspector under section 75. A number of MHRT decisions are anonymised and provided to the New Zealand Legal Information Institute, a publicly accessible online database of legal resources.¹²⁷ These decisions may assist applicants to the MHRT.

12.3.1 Functions of the MHRT

The principal function of the MHRT is to review the condition of a patient when an application for review has been made, or of its own motion, pursuant to ss79 to 81 of the Act. It has three additional functions. Its four functions are:

- To review the condition of patients, special patients and restricted patients, pursuant to ss79 to 81 of the Act
- To investigate complaints of breaches of specific patient rights, where a patient or complainant is not satisfied with the outcome of the investigation of a

¹²⁷ www.nzlii.org/nz/cases/NZMHRT/

complaint by a District Inspector of Mental Health or an Official Visitor, pursuant to s75 of the Act

- To appoint psychiatrists who assess:
 - (i) whether treatment is in the interests of a patient who does not consent to that treatment, pursuant to s59 of the Act
 - (ii) whether electro-convulsive treatment is in the interests of a patient who does not consent to that treatment, pursuant to s60 of the Act
 - (iii) whether brain surgery is appropriate, if the MHRT is first satisfied that the patient has given free and informed consent to surgery, pursuant to s61 of the Act.
- To report to the Director of Mental Health pursuant to s102 of the Act on any matter relating to the exercise or performance of its powers and functions.

The conduct of reviews is expanded on below.

12.3.2 Reviews are required to commence within 21 days, or with an extension by the MHRT, at latest 28 days, of the date of the application being received

Pursuant to s79(5) and (6) of the Act reviews must commence within 21 days of the Tribunal receiving the application. The MHRT can extend that time by no more than 7 days. This means health professionals, lawyers and others involved in a review need to act swiftly as soon as they become aware of an application.

In order to facilitate timely and informed reviews, the MHRT (usually through its Secretariat):

- Issues a Notice of application for review and procedure for hearing, shortly after an application is received
- Convenes a telephone conference, to be attended by the responsible clinician (or in his or her absence a suitably informed clinician or the DAMHS), the patient or his or her lawyer and a member of the MHRT, so that pre-hearing issues may be identified and considered
- Gives notice of the review date. The MHRT endeavours to set convenient dates but with the MHRT members usually flying in from elsewhere, and the sometimes conflicting commitments of the patient, lawyers and health professionals, that is not always possible.

12.3.3 Where applications are heard

Applications are usually heard at a District Health Board or community facility near where the patient lives, unless directed otherwise by the MHRT. It is the responsibility of the District Health Board and DAMHS to ensure that appropriate facilities are made available. These include:

- a room that can comfortably sit 7 to 10 people, with suitable desks and chairs
- a separate interview room

- security where appropriate.

12.3.4 Who usually attends hearings

Hearings usually include:

- the patient and his or her lawyer and support person (if any)
- family or whanau of the patient, if the patient seeks their attendance
- the responsible clinician
- a second health professional.

Other people may attend, as of right in some cases, for example a District Inspector of Mental Health, and in some other cases subject to the discretion of the MHRT.

If a responsible clinician considers that it would be helpful for other people or witnesses to attend then he or she should advise the MHRT of that at an early stage.

12.3.5 What reports health professionals must provide and when

Good quality evidence and especially good quality reports from health professionals are essential to enable the MHRT to discharge its function.

Reports need to fully address the statutory criteria and to assist the MHRT to meet its obligation under s5 of the Act to exercise its powers and conduct proceedings with proper respect for the patient's cultural identity and personal beliefs.

Timely provision is necessary so that the patient and lawyer can prepare and so that the MHRT can understand the issues in advance of the hearing. Timely provision may resolve the issues which led to a review. A minimum of 7 days before a hearing:

- the responsible clinician provides a substantive report to the MHRT, which will properly inform the MHRT of all relevant aspects of the patient and his or her care. In order to assist responsible clinicians, the MHRT has issued Guidelines for reports to the MHRT by responsible clinicians, which are available on the Ministry of Health website
- a second health professional provides a brief report to the MHRT often in the form used for compulsory treatment order hearings.

12.3.6 Decisions of the courts and expert reports in respect of special patient and restricted patient status

When reviewing special patients and restricted patients, the MHRT will usually need a copy of the decisions of the court imposing that status. The reasons include that the decisions:

- Are the foundation for that status
- Contain the grounds for the imposition of that status
- Are a record of the relevant facts and circumstances
- May help in identifying relevant risks and patterns.

DAMHS and responsible clinicians ought to have those decisions as part of their role in providing care and treatment to the patient. If they do not, then they ought to seek them from the Ministry of Justice or courts as soon as they become aware of an

application for review, so that they may be made available to the MHRT and the patient or his or her lawyer.

The MHRT may also need some of the expert reports which informed those court decisions. If so, then the DAMHS and responsible clinicians can seek them from the Ministry of Justice or courts.

12.3.7 The review hearing process

Schedule 1 of the Act contains procedural provisions relating to review hearings, which include some of the powers of the MHRT and the rights of the patient and others involved.

The Schedule to the Act allows for a very formal review process, but the MHRT has broad power to determine its own procedure and tries to reflect a more informal process. It conducts proceedings:

- with proper recognition of the importance and significance to the patient of ties with his or her family, whanau, hapu, iwi, and family group
- with proper recognition of the contribution those ties make to the patient's wellbeing
- with proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs.

These may involve the MHRT co-opting members of the same ethnicity as the patient and also having an interpreter present.

The Ministry of Health website contains practice notes and guidelines issued by the MHRT. They are updated by the MHRT from time to time.

12.3.8 The powers of the MHRT

The MHRT is an independent statutory body. It seeks to operate with the common sense cooperation of those involved in the administration and application of the Act. However, it has significant powers, which mirror many powers of a court and a Commission of Inquiry. It has:

- express powers under the Act, to enable it to perform its functions
- many of the powers available to a Commission of Inquiry, which are conferred on the MHRT by s104(3) of the Act
- inherent powers to regulate its own procedure, to ensure fairness and to prevent an abuse of process.

These include power to:

- require the production of evidence and other material, in a form required by the MHRT
- summons and call witnesses

- require evidence to be given on oath
- determine the extent of evidence to be put before it
- excuse the attendance of the patient, on limited grounds
- permit people other than those specified in the Act¹²⁸ to be present during a hearing, and to require witnesses to withdraw from the hearing
- grant leave to enable the publication of reports of the proceedings (including its decisions)
- call for an independent report on the patient. If the MHRT does so, it is required to order that the costs are met by a party to the proceeding or from a Parliamentary appropriation.¹²⁹

Some of the powers of the MHRT are exercised through the Secretariat. This usually occurs at the pre-hearing stage, for example when sending out notices, seeking reports and allocating telephone conference and hearing dates; after the hearing if further material is sought; and when decisions are issued.

The MHRT's powers are supported by offence provisions and the ability for the Tribunal to report matters of concern to the Director of Mental Health.

12.4 Appeal against Mental Health Review Tribunal decision

Following an MHRT review of a patient under a compulsory treatment order, in which the MHRT finds that the patient remains mentally disordered, any of the following people may appeal that decision to the court:

- Director of Mental Health
- Director of Area Mental Health Services
- the patient
- the patient's welfare guardian (if applicable)
- the patient's principal caregiver
- the patient's primary health care provider
- a district inspector.

An appeal proceeds as if it were an application for review under section 16 (see 5.7 above).

¹²⁸ First Schedule to the Act, cl 7.

¹²⁹ First Schedule to the Act, cl 5.

Figure 3: Clinical and judicial review of patients under compulsory treatment orders

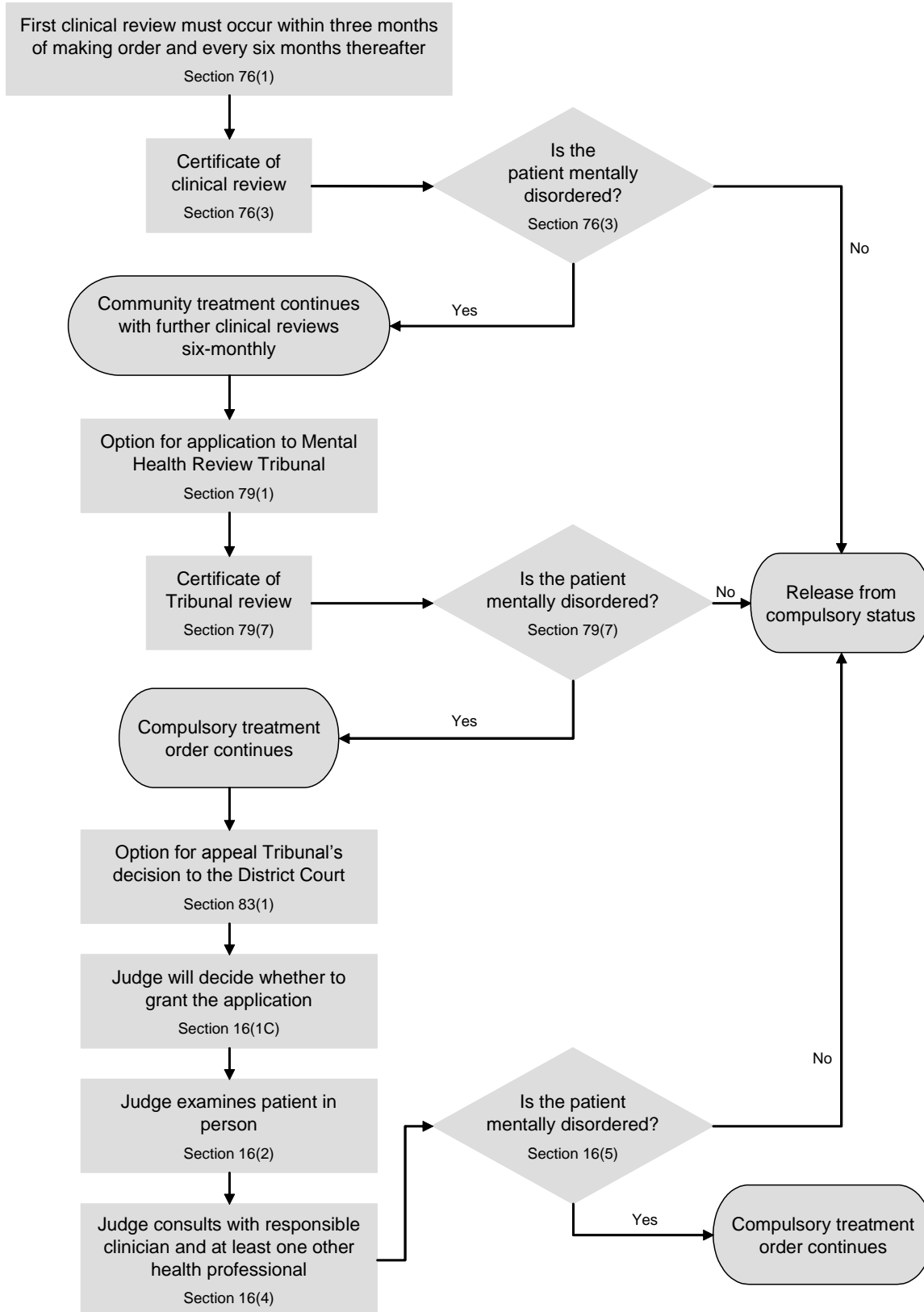


Figure 4: Clinical and judicial review of special patients acquitted by reason of insanity

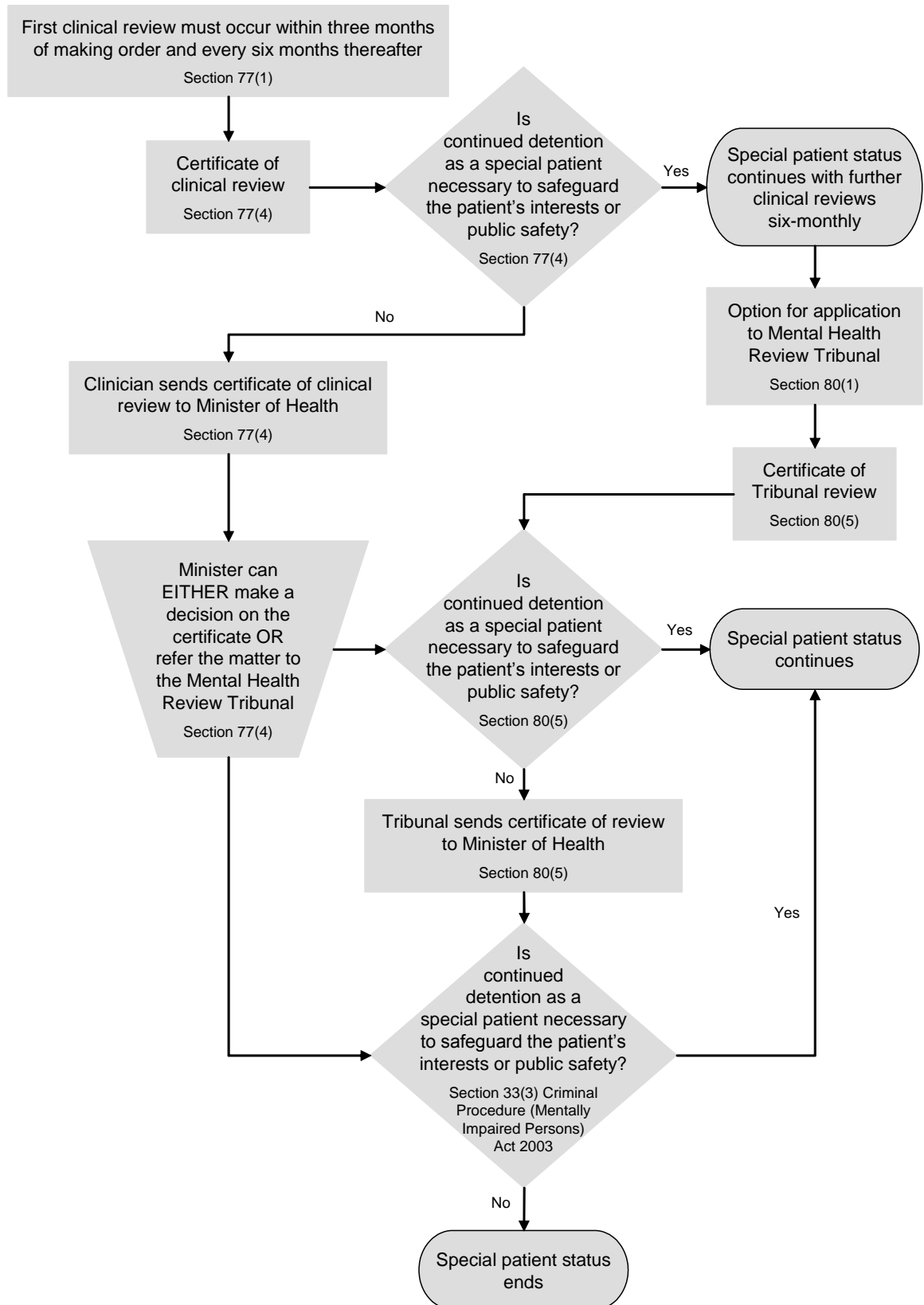


Figure 5: Clinical and judicial review of special patients found unfit to stand trial

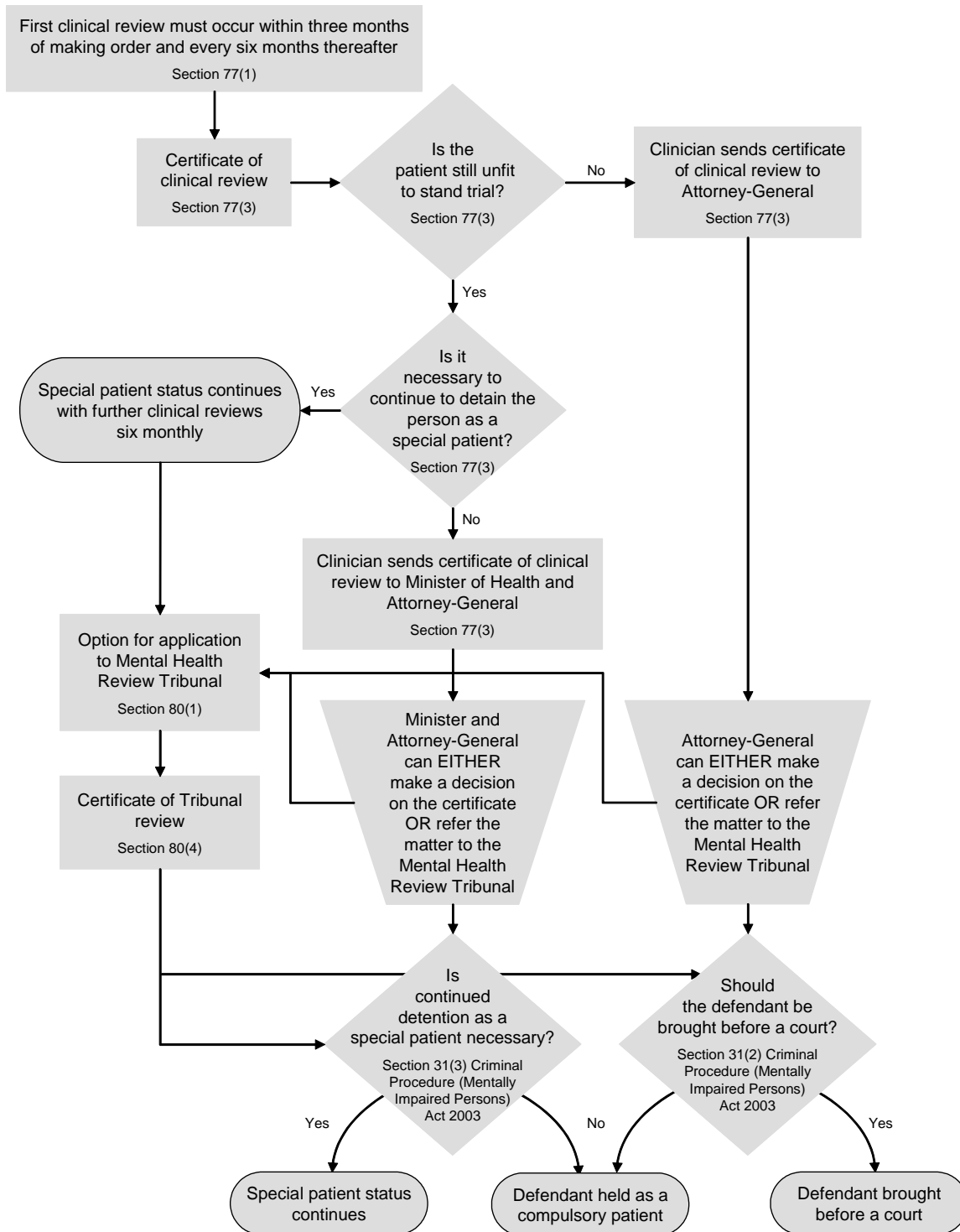
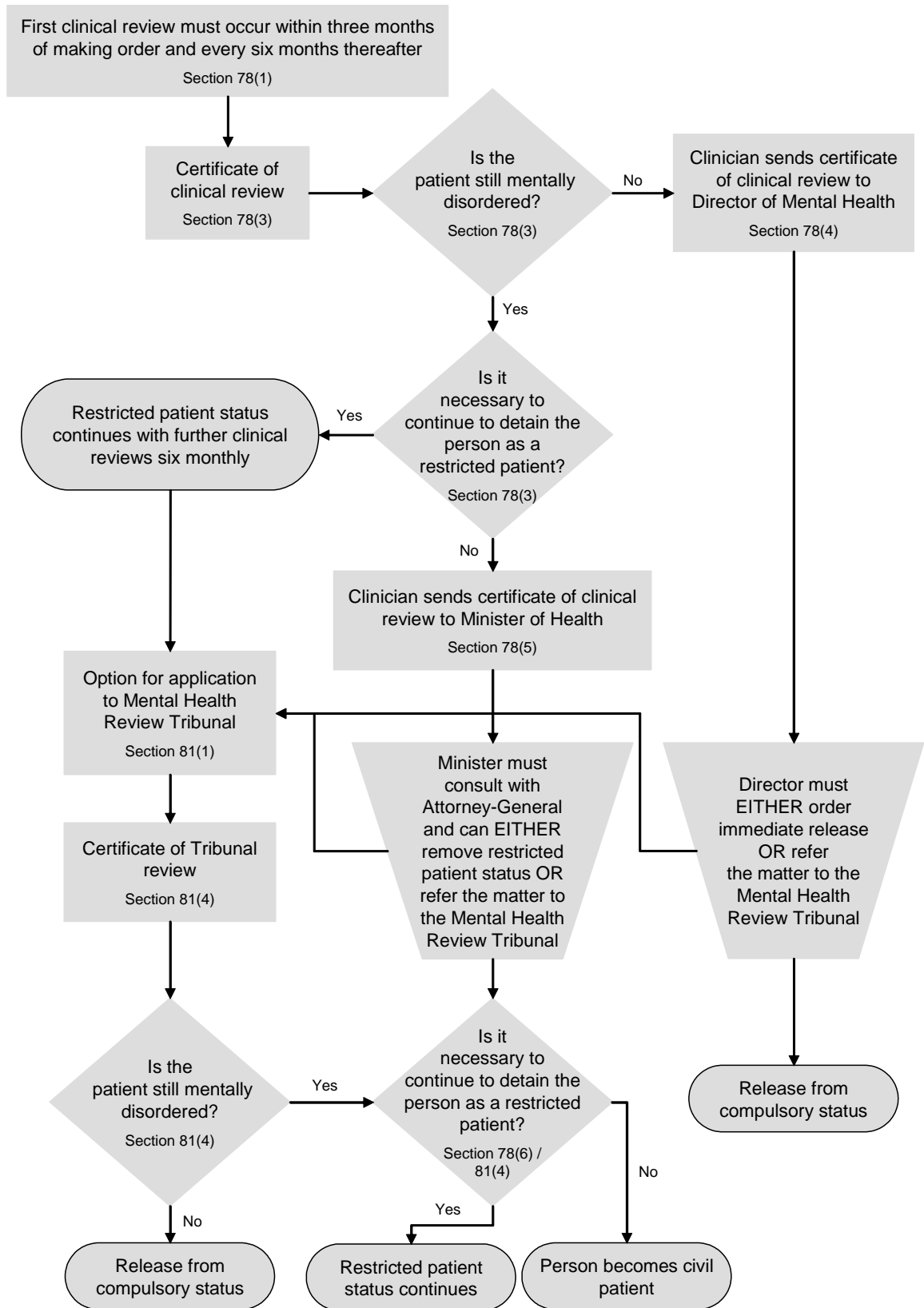


Figure 6: Clinical and judicial review of restricted patients



13 Part 8: Consent for young people and involvement of family/whānau

Part 8 of the Act contains specific provisions governing the treatment of patients and proposed patients who are under the age of 17 years and who are subject to the Act.

Section 86 of the Act states that ‘wherever practicable, an assessment examination of a person who is under the age of 17 years shall be conducted by a psychiatrist practising in the field of child psychiatry’.

For all practical purposes, a young person aged 16–19 years may be treated as if an adult for the purposes of giving consent. It is important to note that ‘in respect of a patient who has attained the age of 16 years, the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of this Act’ (section 87 of the Act).

A child/young person under the age of 16 years may give valid and effective consent if they have a sufficient understanding of the significance of the proposed treatment. This depends on the maturity of the individual child/young person, the effect of the relevant disorder at the time, and the seriousness of the matter for decision. If a child/young person under the age of 16 years is able to give consent, the consent of a parent/guardian is not necessary. If a child/young person under the age of 16 years is unable to give consent, the consent of a parent/guardian is necessary (except in an emergency or as authorised by sections 57 to 59 of the Act).

It is important to bear in mind the central role of family/whānau in the care of children and young people who are mentally ill. Responsible clinicians should ensure that family/whānau are actively involved in the management of such patients. Note that the requirement to fully inform the patient about the treatment (as in 11.4 above) is not displaced by the fact that consent to treatment is sought from a parent or guardian.

14 Part 10: Enforcement powers and offences

Under the Act, Police have a role in protecting an individual, as well as the public, if they have reasonable belief that the person may be mentally disordered.

Under section 109 of the Act, if a person is found wandering at large in any public place and acting in a manner that gives rise to a reasonable belief that he or she may be mentally disordered, if a constable then believes that it would be desirable in the interests of the person or the public, they can take this person to a Police station, hospital, or some other appropriate place.

Beyond the power under section 109 of the Act for Police to proactively engage with a person, clinicians and services are only permitted to request the assistance of Police in certain urgent situations. These situations are clearly specified under sections 110, 110A, and 110B and relate to either the need for an urgent examination or assessment, or sedation is urgently required.

It is important to note that a medical practitioner must also make every reasonable effort to get the advice and assistance of a DAO first, prior to requesting the assistance of Police. This is particularly so if the process concerns a person being assessed under the Act. The assistance of Police should only be used as a last resort and must only be used to assist for one of the purposes described above. Police **cannot** assist with the treatment of a patient or proposed patient.

The only other circumstances in which a service may engage the assistance of Police if a situation arises that falls within their jurisdiction as described under Section 9 of the Policing Act 2008, *Functions of Police*. This includes –

- (a) keeping the peace:
- (b) maintaining public safety:
- (c) law enforcement:
- (d) crime prevention:
- (e) community support and reassurance:
- (f) national security:
- (g) participation in policing activities outside New Zealand:
- (h) emergency management.

14.1 Section 110: Powers of a medical practitioner when urgent examination is required

Under section 110 of the Act, a medical practitioner may request Police assistance to conduct a medical examination (section 8B). A medical practitioner acting under this section must make every reasonable effort to obtain the advice and assistance of a DAO first, prior to requesting the assistance of Police.

14.2 Section 110A: Powers of a medical practitioner when urgent sedation is required

Section 110A of the Act allows a medical practitioner who issues a section 8B medical certificate to administer sedation to a proposed patient in an emergency.

The medical practitioner must have reasonable grounds for believing that the proposed patient presents a significant danger to self or to others and that it is in the proposed patient's interests to receive a sedative drug urgently. The medical practitioner may administer the drug, and if done it must be in accordance with relevant guidelines and standards of care and treatment issued by the Director-General of Health under section 130 of the Act (refer to *Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health April 2000)). The medical practitioner must make every reasonable effort to obtain the advice and assistance of a DAO and may call for Police assistance.

When a medical practitioner administers a sedative drug, they must record the circumstances in which the drug was administered and give a copy to the DAMHS as soon as practicable. The record should be made available to the consultant psychiatrist conducting the assessment examination for the purposes of section 9 of the Act.

14.3 Section 110B: Powers of a medical practitioner when urgent assessment is required

This section relates to an urgent assessment examination under section 9 of the Act. The medical practitioner (usually a psychiatrist) must conduct the examination as soon as possible. The medical practitioner must make every reasonable effort to seek the advice and assistance of a DAO, and may seek Police assistance.

14.4 Section 111: A registered nurse's power to detain

Section 111(2)(a) of the Act allows a nurse to detain, for the purpose of a medical examination, a person who has been admitted to hospital (or who has been brought to a hospital) who is believed to be mentally disordered. The power to detain under section 111 may only be exercised by a registered nurse.

Powers of detention are set out in section 113 of the Act. This detention cannot be for more than six hours from the time the nurse first calls for a medical practitioner to examine the person (section 111(3)). It should be noted that the power to detain is not limited to the premises of a psychiatric unit and should be exercised with discretion, according to good clinical practice.

Section 111 can be used when a voluntary inpatient seeks to leave a psychiatric unit at a time when no medical practitioner is available to assess them and a nurse suspects that the person is mentally disordered.

14.5 Section 113: Authority of the person in charge of a hospital or service to admit or detain

The person in charge of a hospital is authorised to take all reasonable steps to detain a patient or proposed patient for the purposes of compulsory assessment and treatment. The person in charge of a hospital can detain a patient or proposed patient for the purposes of:

- an assessment examination (section 9)
- assessment and treatment as an inpatient (sections 11 and 13)
- an inpatient compulsory treatment order.

The person in charge of the hospital or service may detain a patient or proposed patient in the hospital or service for the purposes of an assessment examination under section 9 of the Act. The period of detention must be no longer than six hours or the time it takes to conduct the assessment examination, whichever is less.

Section 113 of the Act also authorises the person in charge of a hospital to take all reasonable steps to admit and detain an individual subject to the Act. The interpretation of what is ‘reasonable’ will depend upon the balance of the risk to the patient and others and the autonomy of the individual patient.

The powers given to the ‘person in charge of the hospital’ will be exercised in practice by the staff of the hospital. The person in charge should ensure that the staff understand their powers and are properly trained to carry them out as safely as possible.

Detention may sometimes require the use of force. This should be only sufficient force as is necessary to ensure that a patient is detained safely. If needed, physical restraint or seclusion must be carried out in accordance with relevant standards and guidelines.¹³⁰ Consideration must be given to cultural differences when using force, for example avoidance of contact with the head of a Māori patient or proposed patient, if reasonably practicable.

14.6 Section 113A: Judge or registrar may issue warrant

This section authorises a District Court Judge or Registrar to issue a warrant authorising Police to apprehend any person who refuses to attend for an assessment examination as instructed by notices under section 9, 11, 13 or 18, or a hearing under section 19 of the Act, or a clinical review under section 76 of the Act. Police may then take that person to a place specified for such an examination to be carried out. The same power is given in respect of any patient refusing to attend a hospital in accordance

¹³⁰ See *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health February 2010) and the *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (NZS 8134.2:2008).

with a compulsory treatment order or a place of treatment in accordance with a community treatment order.

The application must be made by the DAMHS or their representative. Section 113A of the Act does not confer a general power to seek a warrant for the apprehension of any person who is not cooperating with mental health services or hospital authorities.

14.7 Section 122B: Use of force

Section 122B of the Act authorises a person who is exercising a specified power in an emergency to use such force as is reasonably necessary to:

- take and retake a person
- detain a person
- enter premises.

The use of force should always be considered a last resort. Clinicians should be able to demonstrate that conflict resolution and de-escalation approaches were considered and attempted before using coercion. Any person using force may be criminally responsible if excessive force is used.¹³¹

‘Force’ includes every touching of a person for the purposes of compelling or restricting movement or administering treatment. It will normally be appropriate for clinicians to use minimal force when exercising one of the powers above. ‘Minimal force’ means light or non-painful touching, for example to guide a person towards a building or room or help a person into or out of a vehicle.

There is a clear division of roles between DAOs and Police Officers. A DAO is responsible for the patient; Police for keeping the peace and maintaining safety. In urgent situations requiring police assistance the DAO is deemed to be the official in charge. The Act allows a DAO to use reasonable force under the provisions of section 122B. When a DAO requests Police assistance there is a need to ensure the police approach is not unnecessarily restrictive.

Where the use of force is necessary under the provisions of section 122B of the Act a DAO can request police assistance to:

- Take a person for a examination by a Health Practitioner (section 38(4)(d))
- Take or return a proposed patient or patient to place of assessment or treatment (section 40(2))
- Return a special patient to hospital (sections 50(4), 51(3) and 53)
- Detain a person in hospital for examination by a Health Practitioner if they are thought to be mentally disordered (section 111(2))

When more than minimal or inconsequential force is used while exercising a power under the Act, a log recording the circumstances must be completed by a DAO and forwarded to the DAMHS as soon as practicable. A log for this purpose should include:

- the date, time and place that force was used

¹³¹ See section 62 of the Crimes Act 1961.

- why force was required, including details of de-escalation attempts
- what type of force was applied and by whom
- any injury to patients or staff members involved
- any action or follow-up required as a result of force being used.

Services should refer to the Memorandum of Understanding between the New Zealand Police and the Ministry of Health, which provides guidance to Police and health professionals administering the provisions of the Act, as well as any local agreements made under the Memorandum of Understanding. Detailed guidance around the use of force by DAOs is provided in *Guidelines for the Role and Function of Duly Authorised Officers* (Ministry of Health 2012).

14.7.1 Use of force to administer compulsory treatment

Force as is reasonably necessary in the circumstances may be used for the purposes of compulsory treatment, provided that the processes in Part 5 of the Act relating to consent and second opinions have been followed (section 122B(3)). Force includes minimal touching as necessary to administer treatment (for example, the prick of a needle).

The use of force will not be permitted where the responsible clinician has failed to properly seek consent when treatment is established or changed, or failed to obtain a concurring second opinion where consent is not given. The administration of treatment without compliance with Part 5 could be considered an assault in law. As such the Ministry recommends that responsible clinicians make prudent, good faith efforts to comply with Part 5.

14.7.2 Use of restraint

The Ministry recognises that seclusion and restraint have no therapeutic value, and may be traumatising for both patients and staff. The Ministry supports a reduction in the use of restraint in mental health services over time. The use of a restraint is a last resort that should be avoided wherever possible through the use of less restrictive practices, such as those promoted through *Safe Practice Effective Communication* (SPEC) training. Where restraint cannot be avoided, it must be done safely.

The ability to use force when exercising a power under the Act implies that in some cases restraint may reasonably be used. The *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (the Standards; NZS 8134.2:2008) define the use of restraint as “the use of any intervention by a service provider that limits a consumer’s normal freedom of movement”. The Standards further define four types of restraint¹³²:

- Personal: Where a service provider uses their own body to intentionally limit the movement of a consumer

¹³² New Zealand is the only country to use the term personal restraint, while most other International Initiative for Mental Health Leadership (IIMHL) countries use the terms ‘physical restraint’ or ‘holding’. The most common term used in place of what the Standards define as physical restraint is ‘mechanical restraint’, however some countries (such as Canada, USA and Norway) categorise physical and mechanical restraint together.

- Physical: Where a service provider uses equipment, devices or furniture that limits the consumer's normal freedom of movement
- Environmental: Where a service provider intentionally restricts a consumer's normal access to their environment, for example, where a consumer's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied
- Seclusion: where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.¹³³

Consistent with sections 5 and 65 of the Act, and section 23(5) of NZBORA, services should act to restore the dignity or mana of the patient following an episode of seclusion or restraint.

Principles on the use of restraint

1. Restraint is an intervention of last resort used with the least amount of force necessary when all other options have failed to maintain safety for the person experiencing distress, staff or others in the inpatient environment. The duration of a restraint must be the shortest possible time it takes to safely manage the situation and must be guided by legal, ethical and trauma-informed care principles. All restraint events/episodes must be reviewed, and the staff involved must detail the circumstances leading up to the restraint and explain the rationale for restraining the person.
2. To optimise the physical safety of the person being restrained, these guidelines endorse current SPEC training principles, which does not include flexion based (painful) techniques and avoids wherever possible the use of prone positioning (lying the person face down) due to the increased risk of injury and positional asphyxiation.
3. The decision to use restraint is based on a duty of care in an emergency situation. Restraint is only used to manage significant risk to potential patients and patients, people accessing the service, staff or others and as an emergency intervention when all other least restrictive strategies and approaches have been tried without positive effect.
4. Services are required to work to address the environmental issues that drive the use of restraint. These may include building design, noise levels, line of sight etc.
5. Services are required to work to address systemic issues that drive the use of restraint. These include organisational skills and experience, workplace culture and workforce practice.
6. If a restraint occurs, staff must be mindful of upholding the patient's dignity, privacy and mana at all times. Any breaches of the above are to be addressed with the potential patient or patient as soon as it is practicable to do so.

¹³³ For guidelines to the use of seclusion under the Mental Health Act please see the *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2010).

7. Every person accessing services has the right to be provided with services that take into account the needs, values and beliefs of different cultural, religious, spiritual, social and ethnic groups, including the needs, values and beliefs of Māori¹³⁴.
8. Services must receive training, implement operational policies and strategies in culturally competent best practice approaches that positively and authentically address the high rates of restraint used for Māori and Pacific peoples patients or potential patients.

Working in partnership with Māori

In line with Tiriti o Waitangi obligations, and sections 5 and 65 of the Act services are expected to work in partnership with Māori patients and their whānau. Whānau, kaimahi Māori, cultural advisors, kaumātua and tohunga (where available) should be actively engaged in the promotion of least restrictive best practice including active support and communication with Māori patients and whānau, when restraint occurs. Therefore, in the first instance, these supports should be used wherever practicable before restraint and seclusion is utilised.

Requirement to keep register and to report

Section 122B(4) of the Mental Health Act states that in circumstances in which force is used under provisions as outlined in the Mental Health Act, it must be recorded as soon as is practicable and provided to the DAMHS. Pursuant to section 129(1)(b) of the Mental Health Act, the DAMHS must ensure that in every hospital or service, the person in charge keeps a register of restraint and seclusion in respect of patients subject to the Mental Health Act.

The Health and Disability Services (HDS) Standards require that detailed information regarding restraint activity data is collected by DHBs. According to the HDS Standards, DHB collected data regarding restraint episodes should include:

- reasons for initiating the restraint
- alternative interventions prior to restraint
- any advocacy or support offered prior to restraint
- outcome of the restraint
- injury to any person as a result of restraint
- observations of the service user during the restraint
- comments from reviews and evaluations of the restraint.

Reporting requirements

From July 1 2020, mental health services will be required to report their use of restraint to the Ministry of Health.

Services will initially report their use of restraint via DAMHS quarterly reporting, until mechanisms to report via PRIMHD are established.

Quarterly reporting requirements:

¹³⁴ Code of Health and Disability Services Consumers' Rights 1996

- (a) number of individuals subject to a restraint event
- (b) demographic data
 - i. ethnicity
 - ii. age
 - iii. gender
 - iv. legal status
 - v. date of admission
- (c) sufficient detail to provide an accurate account of:
 - i. type of restraint
 - 1. if personal restraint: whether it was prone
 - ii. length of time of restraint event
 - iii. the reasons for initiating restraint
 - iv. injury to any person as a result of the restraint
 - v. comments from reviews and evaluations of the restraint.

Services should note that when a patient is in a room or area from which they cannot freely exit, this should be recorded and reported as seclusion, regardless of whether the room is designated as a seclusion room by the DAMHS (section 71(2)(b)).

14.8 Section 114: Neglect or ill-treatment of patients or proposed patients

It is an offence under the Act to intentionally neglect or ill-treat patients or proposed patients.

This section applies to:

- the person in charge of the hospital or service where a proposed patient attends for the assessment examination
- the person in charge of a hospital in which the patient is an inpatient
- a person employed in a hospital or service engaged in the assessment of a proposed patient or treatment of a patient
- the person in charge of a home, house or other place where a patient or proposed patient resides.

Such an offence is punishable on conviction by a prison sentence not exceeding two years.

Appendix 1: Other guidelines and documents published by the Ministry of Health

Many of these guidelines are available on the Ministry of Health website (www.health.govt.nz) as current publications or archived in the Ministry of Health Online Library Catalogue, or can be ordered in hard copy, unless otherwise specified.

- *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services (October 2017)* (online only)
- *Guidelines for the Role and Function of Duly Authorised Officers* (November 2012)
- *Guidelines for the Role and Function of Directors of Area Mental Health Services* (November 2012)
- *Guidelines for the Role and Function of District Inspectors* (February 2012) (online only)
- *Mental Health and Addiction Services for Older People and Dementia Services* (June 2011)
- *Te Ariari o te Oranga: the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* (April 2010)
- *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (February 2010)
- *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know* (June 2009)
- *Victim Notification Guidelines for Directors of Area Mental Health Services and DHB Victim Notification Co-ordinators* (November 2007) (online only)
- *Competencies for the role and function of Responsible Clinicians under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (December 2001) (online only)
- *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes* (November 2000) (online only)
- *Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000) (online only)
- *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services* (October 2017)