

# Mental Health and Human Rights

## Submission form

Please take the time to make a submission. The final pages of this consultation document explain how to make a submission and how to make sure it reaches the Ministry in time. There are also questions that might help you to write your submission.

Your feedback is important: it will contribute to a shared understanding of the relationship between the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Convention on the Rights of Persons with Disabilities (CRPD) and the New Zealand Bill of Rights Act 1990 (NZBORA). Your feedback will also shape recommendations to the Ministerial Committee on Disability Issues on the alignment of the Mental Health Act with CRPD and NZBORA.

All submissions are due with the Ministry by **5 pm on Friday, 24 February**.

The Ministry of Health must have your submission by this date and time. Any submissions received after this time will not be included in the analysis of submissions. In making your submission, please include or cite relevant supporting evidence if you are able to do so.

There are two ways you can make a submission:

- fill out this submission form and email it to:  
MentalHealthAdmin@moh.govt.nz

**or**

- mail your comments to:  
Mental Health Act and Human Rights Feedback  
Office of the Director of Mental Health  
Ministry of Health  
PO Box 5013  
WELLINGTON 6145

The following questions are intended to help you to focus your submission. It will help us analyse the feedback we receive on the plan if you can use this format. You are welcome to answer some or all of the questions, and you can tell us about other ideas or concerns you may have as well.

You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed  
 by: *(name)* Leanne Manson

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Address: *(street/box number)* Level 3, 57 Willis Street

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*(town/city)* Wellington 6011

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Email: leannem@nzno.org.nz

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Organisation (if applicable): New Zealand Nurses Organisation - Tōpūtanga Tapuhi Kaitiaki o Aotearoa

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Position (if applicable): Policy Analyst Māori

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Are you submitting this as *(tick one box only in this section)*:

- an individual or individuals (not on behalf of an organisation)  
 on behalf of a group or organisation(s)?

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission and your name(s) will not be listed in the published summary of submissions, if you check the following box:

- I do not give permission for my personal details to be released.

Please indicate which sector(s) your submission reflects  
*(you may tick more than one box in this section)*:

- |                                                                 |                                                                           |
|-----------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Māori                                  | <input checked="" type="checkbox"/> Professional association              |
| <input type="checkbox"/> Pacific                                | <input type="checkbox"/> Justice sector                                   |
| <input type="checkbox"/> Asian                                  | <input type="checkbox"/> Education sector                                 |
| <input type="checkbox"/> Consumers/families/whānau              | <input type="checkbox"/> Social sector                                    |
| <input type="checkbox"/> Service provider                       | <input type="checkbox"/> Academic/research                                |
| <input checked="" type="checkbox"/> Non-government organisation | <input type="checkbox"/> Local government                                 |
| <input type="checkbox"/> Public health organisation             | <input type="checkbox"/> Industry                                         |
| <input type="checkbox"/> Primary health organisation            |                                                                           |
| <input type="checkbox"/> District health board                  | <input checked="" type="checkbox"/> Other <i>(please specify)</i> : Union |

## Questions

These questions relate to the Mental Health Act and its administration.

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

#### About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

NZNO welcomes the opportunity to provide comment on the Mental Health Act (MHA) and Human Rights discussion document. As health professionals, we support any legislation that aims to improve opportunities for people who come under the Mental Health Act to have a good life, and, that also ensure that those with the greatest burden receive equity of outcomes, particularly for Māori and Pacific people who have the greatest burden<sup>1</sup>.

NZNO has consulted its members and staff in the preparation of this submission, in particular members of the Mental Health Nurses Sections, Te Rūnanga o Aotearoa and professional nursing and policy advisers.

As indigenous health professionals, Te Rūnanga work with tāngata whaiora and their whānau, across a wide range of health settings. We draw your attention to Article 24.2 of the United Nations Declaration on the Rights of Indigenous Peoples which states that '*Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right*<sup>2</sup>'.

1. How well do you think the Mental Health Act does in promoting and protecting human rights?

Further work is needed to align the Human Right's Act, the Rights of the Disabled, and the laws surrounding mental health patients to ensure that there are no unintended consequences or barriers to care.

<sup>1</sup> Ministry of Health (2012) Rising to the Challenge Mental Health Addiction. Accessed on 8/3/2017 <https://www.mentalhealth.org.nz/assets/ResourceFinder/rising-to-the-challenge-mental-health-addiction-service-development-plan.pdf>

<sup>2</sup> United Nations. (2008) Declaration on the rights of the Indigenous Peoples. Accessed on 29/10/16 [tshttp://www.un.org/esa/socdev/unpfii/documents/DRIPS\\_en.pdf](http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf)

We are concerned that the Act does not:

- ensure patients are protected from violent assault by other patients;
- protect staff from day to day violence;
- ensure a sustainable, trained mental health workforce commensurate with the health needs of New Zealanders ; or
- ensure that tāngata whaiora receive access to clinically and culturally appropriate care.

Specific comments from NZNO members include the following:

- *The MHA system is tainted with negative legal innuendoes – for example: the mentally unwell person is reviewed by a JUDGE in a COURT. I have often been approached by distressed (mostly elderly) patients who tell me they have not committed any crime but are made to feel like they have. This system needs an urgent review if we are to build and maintain a therapeutic relationship with our patients who should not be made to feel like criminals.*
- *The MHA is coercive and does not do well in recognising the person's right to refuse treatment, when compared with medical/physical unwell choices of treatment.*
- *The current system of maintaining patient's long term under the MHA as a "safeguard", in case they become unwell again, is morally and ethically flawed. It would appear that the reason is to save time with legal paperwork therefore not for the benefit of the patient, but more for the clinician.*

NZNO is acutely aware of the increase violence faced by staff on a daily basis. For instance; recently two nurses have been knocked unconscious, one very seriously, and patients are also adversely affected by the threat and reality of patient assault. Clearly an unsafe working environment is not appropriate for a large number of new recruits who have the responsibility for direction and delegation of other workers, without sufficient leadership and guidance, nor is it at all acceptable for International Qualified Nurses, who are unlikely to be aware of the acuteness of the situation.

NZNO is currently aware that at one District Health Board (DHB), the workload and conditions in mental health services are so dire, that staffing recruitment is not sufficient to retain nurses, and/or ensure appropriate numbers or skill-mix. Workload issues because of understaffing are exacerbated by the DHB having to conform to a clinical model with regard to seclusion and restraint which it is not resourced for.

Nurses should not be expected to bear the physical, mental and emotional consequences of inadequate funding. The DHB must ensure that the government provides the resourcing needed to back the clinical model as directed by the Ministry of Health.

We also note the increase demand for mental health services following the devastating Christchurch and Kaikoura earthquakes which burdened an already under resourced and funded service which requires further assessment and planning for unrealised future needs<sup>3</sup>.

NZNO welcomes new initiatives that address systemic barriers, such as:

- delays in tāngata whaiora or their whānau accessing court services (judge or district inspectors or family court);
- delays in accessing clinical staff when ‘at risk’ assessment are urgently required; and
- reducing the stigma of being treated like a ‘*criminal*’ when tāngata whaiora are subjected to the court system.

2. What changes do you think are needed in order to make the Mental Health Act and its administration more aligned with our obligations under NZBORA and the CRPD?

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<sup>3</sup> National Radio. Bed shortages for Christchurch mental health patients.  
<http://www.radionz.co.nz/news/national/326175/bed-shortage-for-christchurch-mental-health-patients>

NZNO is aware that the protection of a person's human rights during the application of the MHA, is particularly individualised to the Duly Authorised Officers and the clinical staff. Although there is an obligation to include family or whānau, this varies across the country, according to staff and funding resources.

NZNO acknowledges the Convention on the Rights of the Person with Disabilities (CRPD) Article 25 states that 'States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability' and can relate to the MHA right to receive treatment. Although Article 12 would be obviously compromised by the use of the MHA unless the shift from substituted to supported decision making is already embedded within the recovery model. In the situation where compulsory assessment and treatment is necessary, it is likely that there is a tip in balance back towards substituted decision making which appears appropriate under the circumstances.

We recommend further institutional clarity is needed with the criteria for moving from the substituted to the supported model. Clinical judgement would be a guide to this balance – rather than which section of the MHA the service user is currently under. The interpretation of mental disorder remains an issue (with the NZBORA and MHA) with some variance and continues to be contentious when it is applied to people experiencing self-harm or risk to others. In particular, with severity of safety risk is not necessarily related to the presence of symptoms as listed under the mental disorder definition.

We note that the right to refuse treatment is clearly compromised with the use of mental health legislation however the nature of the treatment may be negotiable within many contexts. However the right to security is inherent in the MHA with a purpose to promote safety within the least restrictive environment possible. The right to liberty could be the only notable difference, as the assessment of risk is an important tool in deciding this.

The use of assessment of risk measures tools can vary across district health boards and this may need to be reviewing for relevancy and to determine if evidence based.

Further research is needed with individual competency decisions, clinical judgement and the risk of individual organisation and staff accountability/confidence and benefit.

The recovery model should support the person having as much decision making in partnership in the process of the MHA and treatment options with individuals and clinicians/whānau and family.

Specific comments from NZNO members include the following:

- *I recommend better effective assessment of tāngata whaiora (non-forensic) who are held under prolonged or indefinite community treatment orders (CTOs) as my experience tells me that some are 'held' for too long; it becomes a "rollover" exercise which needs closer scrutiny as the rationale for maintaining this compulsory status for long periods of time "is just in case" the person decompensates.*

## Part Two: Mental Health Act – the Issues

### Individual autonomy/consent

3. Do you think the views and preferences of tāngata whairoa / service users are taken into account sufficiently in decisions about their treatment? What is your experience?

We note that there is considerable variation in the process of decision making which varies and is dependant on clinical context and clinicians. There needs to be a greater focus on advance directives.

We believe that there needs to be a stronger emphasis on partnership processes with more vulnerable age groups e.g. young people and older adults.

We recommend that further education is required for clinicians about the Acts definitions of informed consent and consent as it is often not well understood.

Specific comments from NZNO members include the following:

- *I completely agree with the comments about medication not addressing trauma and the lack of presentation of treatment options other than medication. There seems to be an assumption that the word treatment=medication. I have seen many situations in which the service user has been discharged due to refusal to accept treatment when in fact they were refusing medication and nothing else was on offer. This is not acceptable and vulnerable people deserve better care options.*
- *The side effect issue is very important and often under-estimated in significance. This needs more exploration with the service user and should be an aspect of treatment planning in advance directives.*
- *From my limited experience in this area I have witnessed respectful and inclusive information sharing between service users, whānau and clinicians.*

4. What is your experience of consultation with the families and whānau of both adults and young people subject to the Mental Health Act, including in relation to treatment options? Is it culturally appropriate? How could it be improved?

As previously noted, there is considerable variation depending on clinical context and clinicians. I think family or whānau involvement has improved in many contexts but there are still some clinicians who believe they “know best”.

We agree that these issues require sensitively (adult experience only) and in accordance with Tikanga Māori, and in respect of the older person, as this age group has its own specific culture.

Specific comments from NZNO members include the following:

- *Sometimes the options presented are narrow.*
- *Usually there is a concerted effort to consider appropriate cultural approaches but this is dependent upon local resources. When a cultural resource is limited, there tends to be a return to the “one approach fits all” method rather than an attempt to delay the consultation and decision until such support is available.*
- *Time is generally an issue in treatment discussions – there is always a sense that people need to make decisions quickly. That may not always be the case.*

### **Advocacy and support**

5. How might tāngata whaiora/service user decisions be better supported?
  - a. What supports are needed by seriously ill mental health patients to make decisions?
  - b. What about those persons with mental illness who do not have support networks?
  - c. What is the role of peer support, independent advocates and advance directives in supporting decision-making?

Specific comments from NZNO members include the following:

- *Without devaluing peer support, there is also a place for both independent clinical and independent legal advocacy. This support could be offered through the legal process and in the development and implementation of advance directives. Such advocacy would provide reassurance in relation to the four key issues of advanced directive and would provide validity as identified by the Health and Disability Commission. This advocacy would also assist those service users with limited networks.*
- *Advance directives are very important and should be used in combination with genuine (not tick box) relapse prevention plans.*
- *In my specialty of electroconvulsive therapy (ECT) a patient reported resistance from his psychiatrist over an advanced directive; e.g. the patient stipulated to his psychiatrist that, should he become unwell again, he wished to have ECT as he had tried many antidepressants, had too many side effects and they had not work for him. The psychiatrist tried to persuade him not to express the wish to have ECT in the advanced directive.*

### **Checks and balances in the system**

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

Te Rūnanga acknowledges the Human Rights Commission document 'A Fair go for all' which indicated that in health another form of structural discrimination is the under representation of Māori in the health workforce<sup>4</sup>. As health professionals, we understand why it is necessary to be proactive in addressing health inequity and know from the evidence-base<sup>5</sup> that ensuring access to culturally appropriate mental health services for all tāngata whaiora is an essential first step in promoting better health outcomes for all who access the services.

NZNO agrees that most nursing students are educated on inclusive models of health and wellbeing like Mason Durie's Te Whare Tapa Whā (Ministry of Health, 2009) that places holistic approaches to one's health and wellbeing based on four corner stones of a whare, it is essential that overseas registered health professionals are required to complete any bicultural training before working with Māori.

We note, that it would be beneficial to have a national resources designed to specifically to assist the groups listed above in their navigation through the MHA.

With a growing incidence of people with dementia, NZNO is aware that there will be a greater demand for staff with training and expertise in dementia.

Our members have specific highlighted the current gaps in the system:

- *From my experience in Auckland, services are available to assist tāngata whaiora of Māori, Pasifika and Asian ethnicity however these services are not available across the country.*
- *I do see gaps in the system both with resourcing and specifically trained staff to work with younger people, people with learning disabilities and older adults with dementia (who are particularly vulnerable group who regularly have their views discounted).*
- *There is a growing need for an independent clinical advocate with expertise in identifying groups who could accompany or consult with District Inspectors, Review Tribunals, DAOs etc.*

## **Respect for cultural identity and personal beliefs**

### **7. What is your experience of cultural competency in the services provided under the Mental Health Act? When should cultural assessment be used?**

Te Rūnanga strongly recommends that services for Māori should recognise cultural needs and continue to shift to a whānau based delivery model grounded in tikanga and be culturally responsive services. As frontline health service staff, our members play a vital role in providing better services for tāngata whaiora, their whānau, or families.

<sup>4</sup> Human Rights Commission. (2012) *A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services*. Wellington: Human Rights Commission.

<sup>5</sup> Russell, L., Smiler, K., Stace, H. (2013). *Improving Māori Health and Reducing inequalities between Māori and non Māori: has the primary health care strategy worked for Māori? An evaluation of the period 2003-2010*. Wellington: Health Research Council of New Zealand and Ministry of Health.

We recommend that culturally appropriate training should be provided to support the wider workforce to practice in a responsive, safe and competent way.

Recent research by Durie, Kingi, Elder and Tapsell also identifies the influence of race, cultural competence in practitioners, and colonisation as significant in the way mental health services assess, respond to and treat Māori<sup>6</sup>.

One member notes:

- *From my experience, my DHB ensures that cultural assessments are conducted effectively and services provided by Kaitakawaenga in our mental health services for those tāngata whaiora having ECT.*

8. What do you think constitutes ‘proper recognition’ of whānau, hapū and iwi in terms of use of the Mental Health Act? (This is set out in the Mental Health Act guidelines: it is not defined, but it is described).

9. What changes would you like to see?

- NZNO acknowledge and recognise the integral importance of whānau, hapū and iwi in the oranga, care and management of tāngata whaiora.
- We acknowledge the concept of Whānau ora that aims to place whānau at the centre of service design and delivery to empower and realise their own solutions; but also demands greater accessibility, integration and coordination amongst services<sup>7</sup>.
- These strategies are all reliant however on a Māori workforce to deliver a ‘Māori for Māori by Māori health service delivery to addresses disparities. We strongly believe that the Māori health workforce is a key factor in any long-term strategy<sup>8</sup> to improve Māori health outcomes and requires dedicated development and resourcing.

Specific comments from NZNO members include the following:

- *Cultural competency appears well embedded within systems and education however the application of these skills is variable across all health care settings and health professions.*
- *More exploration of “personal beliefs” would be helpful. It is disquieting when cultural beliefs are accepted but convictions arising from religious or personal values around medication and treatment are ignored or determined to be symptoms.*

## Compulsory treatment orders

<sup>6</sup> Te Pou (2014) Supporting seclusion reduction for Māori Taiheretia. Accessed 10/3/17 <http://www.tepou.co.nz/uploads/files/resource-assets/supporting-seclusion-reduction-for-maori-taiheretia.pdf>

<sup>7</sup> Te Puni Kōkiri website. 2015. Whānau ora. Retrieved on 8/3/2016.

<sup>8</sup> Ministry of Health. 2006. *Raranga Tupuake – Māori Health Workforce Development Plan*. Wellington: Ministry of Health.

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

Specific comments from NZNO members include the following:

- *partnership based recovery planning should reduce some of the negative impacts of the legal process.*
- *Lack of access to timely and appropriate services result in a delayed engagement in the system which sometimes means that early intervention strategies arrive too late. This is particularly evident in mood disorders – compulsory treatment may not have been necessary if assessment and treatment had commenced earlier.*
- *This is comparable to any unwell person, mental or medical health: if they do not have the resources or support they will become more unwell.*
- *Yes – some of our patients are maintained on long term CTOs even though they willingly accept ECT.*

## Seclusion and restraint

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

Te Rūnanga is extremely concerned with the high rates of seclusion for tāngata whaiora. Recent research by Māori mental health nurses<sup>9</sup> indicates that: “*the impact of seclusion on tāngata whaiora is traumatising. It has the potential to trigger issues from old traumas, resurfacing feelings and thoughts from past abuse which may not have been resolved. For some tāngata whaiora, the depth of trauma was felt spiritually, at a personal wairua level that needed cultural redress*<sup>10</sup>”.

We are also aware of the urgent need to increase the content of mental health nursing education in nursing programmes to improve care of tāngata whaiora.

Our members have made specific comments:

- *Both the undergraduate and post-graduate nursing programmes need urgent reviewing to increase the content of mental health nursing education. This would also require the inclusion of Te Pou 6 (core strategies to reduce restraint and seclusion) which are core essential to mental health nursing practice.*
- *While there is a great level of commitment to SPEC training this is redundant without an understanding of mental illness, psychosocial assessment and trauma informed care.*
- *Nurses need high levels of assessment and intervention skills to be able to detect symptom deterioration and behaviour escalation and to intervene skilfully.*
- *Caution is required in analysis of reduced seclusion rates – it is possible that the reduced rate may result from service user discharge or increased medication – as this is not always positive.*

## Indefinite form of compulsory treatment order

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

## Final comments

Is there anything else you want to tell us? If so, feel free to make any further comments here.

NZNO recommends that you note our submission, and we welcomes further opportunity to be involved in this review.

<sup>9</sup> Te Pou (2014) Supporting seclusion reduction for Māori Taiheretia. Accessed 10/3/17

<http://www.tepou.co.nz/uploads/files/resource-assets/supporting-seclusion-reduction-for-maori-taiheretia.pdf>

<sup>10</sup> Mental health foundation (2016). *Legal Coercion Factsheet*. [www.mentalhealth.org.nz](http://www.mentalhealth.org.nz) accessed 9/3/17.