

Transforming our mental health law – MHNS submission

Introduction

To start, we'd like to find out more about you.

1. What is your name?

Name Brent Doncliff

2. What is your email address?

If you enter your email address then you will automatically receive an acknowledgement email when you submit your response.

3. Are you submitting:

On behalf of an organisation? If so, please list the name of the organisation below.

Mental Health Nurses Section (NZNO)

4. What best describes you?

The Mental Health Nurses Section is a specialty professional section of

the New Zealand Nurses Organisation dedicated to the provision of leadership, education and professional development of mental health nursing in New Zealand/Aotearoa.

5. What is your ethnicity?

New Zealand European; Māori - Ngai Tahu, hapū Flutey

6. Which age group do you belong to?

55–64 years

7. What part of the country do you live in?

West Coast

8. Official Information Act responses

Include my personal details in responses to Official Information Act requests

9. How can legislation help embed Te Tiriti o Waitangi?

Response: Our history of forcing people to do things ‘for their or others own good’ [including mental health legislation] is fraught with mistakes and mis-steps. In a time when people of all races are suffering economically and personally, while others seem to have resources and privilege, then it will take much education and openness of the process

so that people can see the benefit for all from legislation designed to embed Te Tiriti. While providing equity for Tangata Whenua - the benefit of any practices arising from legislation should be seen to be able to benefit all disadvantaged people, not just those who identify as Tangata Whenua.

There are many ways in which legislation could mandate such practices and embed Te Tiriti. For example, responsibility for providing information and support to ensure that patients' rights are upheld, under the current law, sits with a District Inspector appointed by the Crown. Compliance with Te Tiriti would mean that such support and assurance should be provided by an agent appointed by, and accountable to, both treaty partners.

Viewed as a power-sharing agreement, Te Tiriti would require all roles and functions with authority over the assessment and treatment of tangata whaoira to be dually accountable in this way.

10. What kaupapa Māori principles should the legislation incorporate?

The Ministry of Health [2021] public consultation document comments, "Mental health services are encouraged to have kaupapa Māori models of care available for Māori under the current Mental Health Act and to use traditional Māori processes, such as mihi whakatau, to better welcome and support Māori individuals who are coming into care." "While encouraged," it adds, "these specific practices are not currently required by any legislation." The apparent suggestion is that the new legislation could mandate these models and practices.

I support this suggestion, but also note that this would require a massive increase in resourcing. The case of the three DHBs in the Lower North Island sub-region (CCDHB, HVDHB, WrDHB) illustrates the point. The number of Māori adults in contact with DHB kaupapa Māori services in these districts between 2014 and 2020 has ranged from 339 to 391 per

year. Over the same period, the number of tangata whaiora Māori in these districts who were subject to compulsory assessment and/or treatment, in inpatient and respite settings alone, ranged from 689 to 923. And treatment in these settings represents only a small proportion of compulsory treatment under the MHA, with the majority occurring under section 29 in the community.

It is difficult to see, even with no budgetary restrictions and greatly reduced numbers subject to compulsory assessment and/or treatment, where the workforce could be found to provide kaupapa Māori models of care for all these tangata whaiora. The onus for non-provision will sit with the clinicians putting them in a position of inevitable blame for not providing such approaches. The workforce available to meet this outcome will not be available in the foreseeable future - little action has been taken to increase the mental health workforce except in the primary health space - this is not the service providing compulsory assessment and treatment.

There is greater scope for new legislation to mandate the use of traditional Māori processes to better welcome and support Māori individuals who are coming into care. Perhaps a process that incorporates the aspects of the Hui Process as suggested in Lacey et al. (2011)*. Not everyone who has Māori lineage/ancestry identifies as Tangata Whenua, but even these people and Tauīwi will benefit from a generalised form of this process/framework.

Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: a framework to enhance the doctor-patient relationship with Māori. *New Zealand Medical Journal*, 124(1347), 72-78.

11. What effect will embedding Te Tiriti o Waitangi into practices have for other population groups (for example, children, disabled people, etc)?

See above.

12. What should be the purpose of mental health legislation?

Laws should be for the protection of a person/individual, their whānau/family/significant others and the general public when a person is talking or behaving in such a way which indicates they have an abnormal thought process [and associated behaviour] as a result of temporary or enduring mental illness and they may pose a risk to themselves or to others as a result of that thought process, talk or behaviour - to the degree that if, following specialist mental assessment, it is deemed that the degree of risk is minimal or remote then the person should be allowed to 'go on their way'. Enforced mental health treatment can only be justified where there is, on the balance of specialist opinion, an ongoing and unacceptable risk to the person, their family/whānau or wider society. When making a decision about compulsory mental health treatment specialist opinion should be sought from medical/psychiatric, cultural, and (if needed) educational specialists.

13. If new legislation does not allow compulsory mental health treatment, what requirements should be in legislation to protect an individual's rights and prevent an individual being coerced into accepting mental health treatment that they might not want?

FIRST: If there is no provision for compulsory mental health treatment, then there needs to be a clear understanding that a person with a mental illness, or who is posing a risk to themselves or others because of their abnormal psychology must be treated as a criminal if they act in a way to cause danger or harm to others. The criminalisation of the mentally ill is something to be avoided, but it needs to be understood that people need to be protected from their own actions [and others also need to be protected] if the person would not have acted in that way to cause danger or harm to others if they were not suffering from abnormal mental functioning. It is axiomatic that criminal law is only employed after an offence [such as harm to others] has been committed. It is not the function of the criminal justice to prevent harm from occurring. Prevention and amelioration of harm is instead the general function of the New Zealand health system. The current 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, in situations where these people may cause serious harm to themselves or others and are gravely impaired in caring for themselves. If this framework is removed in the new legislation, the ability of the health system to perform its function would be undermined. It is unlikely that the New Zealand public would find this change acceptable. The discussion document reminds us that the Crimes Act can prevent a suicide or an offence. This is an interesting point. How many police officers would be willing to use the Crimes Act in the situation of mental disorder and what then? Force used to stop the person killing themselves then where?

SECOND: Where someone has an enduring mental illness that may lead them to act in ways that are not in their own best interests, then the appointment of a guardian under the Protection of Personal and Property Rights Act 1988 would be appropriate.

THIRD: There needs to be freely available psychiatric/medical consultations, regular physical health checks, and free and easy access to necessary prescription medications - so that there are no economic barriers to people obtaining needed health advice and medications. There needs to be a collaboration by WINZ & Primary (and Secondary) Health Organisations that structural and economic barriers to obtaining timely health assessment [including mental health assessment] are identified and eliminated/addressed as early as possible in the process.

14. What effect might new legislation that does not allow compulsory mental health treatment have for particular population groups (for example, children, disabled people, etc)?

If new legislation does not allow compulsory mental health treatment, the negative effects will be felt most strongly among population groups who are already disadvantaged.

This has been seen in the debates around vaccination against Covid-19. One section of the population has prioritised the rights of individuals to refuse a medical treatment which is effective at preventing harm. Australian research into the domestic anti-vaxxer movement in Melbourne [[Lopez, 2021](#)] suggests that it is made up of people who are wealthier and more privileged than the general population, and therefore less vulnerable to severe illness and death from Covid-19.

The [New Zealand Human Rights Commission has argued](#) in relation to Covid-19 that there are times when limits on the rights of individuals to refuse medical treatment can be justified, and when a balance must be struck between the rights of individuals and the right to public health and safety. The High Court, in the case of [Four Aviation Security Service Employees v Minister of Covid-19 Response](#), has accepted this argument. Applying coercion to accept medical treatment, for example through vaccine mandates for health workers and others, has also been justified on the grounds that the right to health and safety for vulnerable groups (including children and Māori) can take precedence over individual rights.

There is a significant overlap between the groups who are more vulnerable to Covid-19 and the groups who are more vulnerable to harmful effects of untreated mental health problems. If the new legislation prioritises the rights of individuals and does not allow compulsory treatment, the effect would be analogous to allowing the anti-vaxxers win the debate and set New Zealand's public policy on vaccine mandates.

16. If legislation allows compulsory mental health treatment, when should compulsory mental health treatment be allowed?

Only at those times when there is a clearly identified (or initially assumed) significant risk to self or others to the extent when the risk has been assessed and likelihood of adverse outcome has been eliminated or reduced to an 'acceptable' level - through time, medical or social

intervention then the need for compulsory treatment should be reviewed.

Discussion document - "New legislation can support mental health services to shift their focus from reactive risk management to proactively supporting the safety of people, with the concept of safety defined from the perspective of the person rather than the practitioner." This comes from the *He Ara Oranga* report with its focus on mild to moderate illness and the lack of attention to the voices of mental health professionals. What does it mean for people who are acutely suicidal or psychotic?

There will always be risks associated with people who suffer from altered states of mental functioning due to acute or enduring mental illness, acute or chronic stress or other factors beyond their own control. There is a need for debate and identification of what could/should be an acceptable level of risk. There has been media and professional commentary about the current mental health legislation being interpreted in a 'risk averse' manner inasmuch that some people under compulsory treatment orders remain under these orders for longer periods than is needed. Were this situation to change and people be released from compulsory treatment while still being assessed as having a risk to themselves or others, then to what degree do the treating clinicians who were involved in the mental health care of the person prior to being released from compulsory treatment share in any legal/professional liability should that person who was released from compulsory treatment then stop mental health treatment and then behave in such a way that harms themselves, other people, or property/animals? In short, what is an acceptable degree of risk, who makes this determination, and what indemnity is given to the people involved in making this determination when an adverse/sentinel event happens soon after a person is released from compulsory mental health treatment?

17. If legislation allows compulsory mental health treatment, how should 'mental disorder' be defined, or do you think another phrase and definition should be used, and if so, what?

Perhaps.. “an abnormal state of mind leading to abnormal thought process [and associated behaviour] as a result of known or suspected temporary or enduring mental illness, acute stress reaction or other reason that may pose an unacceptable identifiable risk to themselves or to others as a result of that thought process, talk or behaviour.

18. If legislation allows compulsory mental health treatment, where should compulsory mental health treatment be allowed to occur (for example, in hospitals and/or community settings and/or other facilities)?

Compulsory treatment should only take place in an environment provided by registered mental health practitioners and, if treatment is considered to be safe in the community, registered health practitioners should be available for rapid assistance for whānau and caregivers. The Health and Safety at Work Act 2015 must be a consideration in relation to where health practitioners can work, and what processes are in place to eliminate, minimise or manage identifiable safety risks for workers in whatever environment they work.

21. If legislation allows compulsory mental health treatment, which health professionals should be allowed to assess whether a person needs compulsory mental health treatment?

Only registered health professionals who have education and expertise in assessing mental status, mental health risk assessment and management and awareness of current/contemporary treatment resources and availability.

22. What criteria should the legislation use to say when compulsory mental health treatment is allowed?

There has to be a judgement between the risks of not enforcing treatment and also the rights of the person to self-determination; and

also consideration of safety and wellbeing of family/whānau/caregivers who may be detrimentally impacted if a mentally unwell person who needed treatment was to be returned to their care - but they did not have the necessary skills and/or experience to deal with the degree of mental distress or behaviors of that person.

23. If decision-making capacity is a criterion, what matters should be relevant to an assessment of whether a person has the capacity for the purposes of mental health legislation?

Everyone has varying degrees of capacity to make decisions. The consideration in relation to decision-making capacity is that in any given set of circumstances does the person have the ability to make a decision that, given different circumstances, they would still make. As many decisions have consequences - sometimes even lethal outcomes - the need for careful consideration of the current circumstances, determining if there has been any recent changes in presentation (intoxication, presence or exacerbation of delusions/hallucinations, changes in mood) which may lead to the person to make decisions that are not 'clear headed' which could lead to detrimental outcomes for themselves and/or others. The input of close family and/or significant others during the assessment processes is essential to obtain evidence of change in presentation, functioning and/or other circumstances.

24. Who should assess whether a person has the capacity to make a decision about mental health treatment?

A registered mental health practitioner who has undergone training in capacity assessment, in consultation with the close family/whānau/significant other of the person concerned.

25. If additional criteria for when compulsory assessment and treatment can be used are related to risk, how should these criteria be framed?

Discussed earlier.

26. How would the criteria for compulsory mental health treatment reflect te ao Māori?

The need to engage and involve the person and their family/whānau/significant others and where possible work toward a shared understanding of the issues related to presentation and the immediate plan of care and timing and involvement of reviews.

According to [Ministry of Justice \[2001\]](#), “individual rights were generally superseded by collective rights” in the Māori world.

27. How should the legislation address cultural considerations in the requirements for when compulsory mental health treatment can be used?

Use of interpreters and cultural advisors should be used at the earliest opportunity - even if via telephone or audio-visual. Interpreters and cultural advisors should be trained and understand basics about mental health/illness, the mental health legislation and the processes embedded in the legislation/regulations.

30. How might a supported decision-making process reflect te ao Māori?

According to [Ministry of Justice \[2001\]](#), “While Māori kin groups had kaumātua, rangatira or ariki as leaders, these leaders did not make decisions on behalf of their kin group without first consulting with them. Meetings would be held to discuss the issues and a consensus would be gained as to the appropriate form of action. “I think our whole philosophy of consensus...wasn’t such a bad philosophy. It took a lot of time, but it meant all shades of the arguments were heard. There was a chance to discuss them, they could be dismissed or supported depending on how they felt about them, which I think is a very healthy way of coming to

resolution, whether it was dispute resolution, or political resolution or domestic resolution...”

This sets out how the meeting or hui, as a supported decision-making process, might reflect te ao Māori in coming to a resolution around treatment options.

33. What, if any, restrictive practices should the legislation allow?

Personal, environmental or chemical restraint only to the degree where extant risks of harm to self or others is evident as a result of the presentation/behaviour of the person. It must be reviewed by the treating team including medical and nursing staff every two hours (possibly extended to 6-8 hours overnight if the medical staff are on-call [but nursing staff should still review every two hours and terminate restraint if deemed safe to do so]). Restraint should be terminated at the earliest safe opportunity.

Under the [Ministry of Health \[2010\] Guidelines](#), the following are situations where, according to the duty of care, seclusion as a form of restraint may be appropriate:

- (a) the control of harmful behaviour occurring during the course of a psychiatric illness that cannot be adequately controlled with psychological techniques and/or medication
- (b) disturbance of behaviour as a result of marked agitation, thought disorder, hyperactivity or grossly impaired judgement
- (c) to reduce the disruptive effects of external stimuli in a person who is highly aroused due to their illness
- (d) to prevent harmful or destructive behaviour, using specific indicators of impending disturbance which may be identified by either the individual or the staff, and which should wherever possible be part of an agreed

management plan.

If, under the new legislation, restraint is no longer permitted in the mental health system, then the social control of harmful behaviour will be undertaken by other agencies. Echoing points made in response to Question 13 above, the primary agency likely to be called upon most often to control harmful behaviour in hospitals is the New Zealand Police.

Referrals to other agencies are likely too, however, such as WorkSafe NZ. As the regulator, WorkSafe's functions include engaging with duty holders, educating duty holders about their work health and safety responsibilities and enforcing health and safety law. A guiding principle of the Health and Safety at Work Act 2015 is that workers and other persons should be given the highest level of protection against harm to their health, safety, and welfare from work risks as is reasonably practicable.

The regulatory impact statement for any legislation which disallows restrictive practices in hospitals should be extensive.

For optimal conditions of least restrictive practices, mental health services require sufficient mental health registered professionals with adequate undergraduate and post graduate education (including mental illness, risk assessment and management and therapeutic techniques beyond the minimalist approaches evident in current training such as SPEC). More specialist undergraduate training is required for nurses and medical staff working with people requiring compulsory assessment and treatment. The environment in which such restriction occurs should be designed with adequate space and therapeutic surroundings.

34. How should legislation ensure the use or prohibition of restrictive practices reflects te ao Māori?

Family/whānau to be involved in decision-making and allowed opportunity to remain with the person where they so request and the request can be facilitated. This could reduce the need for seclusion, if there is a safe area where the person and their whānau can be located and can be safely observed/assessed. Medications, per best practice, should be explained to the person and their family/whānau. Any request for use of rongoā or complementary medications should be approved where these are assessed as not being contraindicated to current treatment. Full explanations should be given of why anything is not approved to be used.

35. If any restrictive practices are allowed, what rules should be in the legislation about their use?

Legislation is a blunt tool. It is preferred that Regulations under the Act be approved to determine what restrictive practices are approved for use, and any mandated review mechanisms. It is suggested that a 'learning organisation' approach be included in the Regulations so that each instance of the use of restrictive practices being used is reviewed to determine the circumstances and if things could be done differently to reduce the likelihood of the restrictive practice being needed in similar circumstances. It is important to stress that a non-judgemental approach must be taken in these internal reviews - the goal is to learn and identify where/if changes in clinical practice can be used to minimise restrictive practices.

36. What rules should legislation include to ensure patients and staff are safe whether or not restrictive practices are allowed?

Using the Health and Safety at Work Act 2015 guidance - there needs to be a balance so that staff, other service users, visitors can be kept safe. Local policies and procedures should be formulated under the Regulations to the mental health legislation. These policies and procedures should identify and address staff, personal and group safety, and safety of property and furnishings - so that a suite of approved practices are identified from lowest impact to higher impact so that safety and security measures are

appropriate for the situation.

37. What effect would allowing or prohibiting restrictive practices have for particular population groups (for example, children, disabled people, etc)?

There are particular concerns related to the care and protection of children - this places an additional duty of care for mental health practitioners.

41. How, if ever, should legislation require the involvement of family and whānau, where appropriate?

The involvement of family is critical and should be mandated – except in the circumstance of family violence as discussed below.

42. How would any requirements for family and whānau involvement reflect te ao Māori?

Addressed earlier.

43. What rights and responsibilities should family and whānau be given in the legislation?

There is a balance between the individual and the family/whānau rights/responsibilities. Unless there are specific contraindications, then family/whānau should be provided with information and their input sought - as they may have information/insights crucial to making a determination about the best plan of action to care for the person being

assessed/treated. In any case, any communications should fit within the Privacy Act 2020, and associated Health Information Privacy Code.

44. When is it appropriate not to require the involvement of family and whānau?

Best practice is to involve family/whānau/significant others, except where there is intimate partner violence or family violence (including child abuse and neglect). However, in a situation that is fast moving and immediate action is needed to ensure safety of the person or others, then this should be the priority. Once immediate safety issues have been addressed then contact should be made with family/whānau.

45. What information, if any, should legislation require to be shared with family and whānau?

Family/whānau should be provided with information to enable them to understand the current situation. If they are directly involved in the day-to-day care of the person being assessed/treated then within the Privacy Act 2020, and associated Health Information Privacy Code are guidance that allows more specific information to be shared to enable them to continue their role in the day-to-day care of the person.

53. How should the legislation treat a person with decision-making capacity in the justice system who does not want to receive mental health treatment?

This would depend on the likely impact this would have on others. If their decision to not have treatment results in an easily foreseeable situation where other people are at risk then their decision would need to be reviewed. I expect that the Mental Health Review Tribunal [or similar such agency] should have the power to investigate and recommend appropriate action to the Court - perhaps under the Protection of Personal and Property Rights Act 1988 to have a Welfare Guardian appointed.

55. How should compulsory mental health treatment be applied for a person found not guilty by reason of insanity?

I would expect that s. 24 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 should still cover this situation. Irrespective of the new mental health legislation there still needs to be provision for secure detention and treatment of mentally ill offenders.

57. Who should be responsible for approving the use of compulsory mental health treatment?

As per the current MHA, a judge should be used if the assessed need for compulsory treatment is longer than a few weeks.

58. What should be the process for approving the use of compulsory mental health treatment?

Similar graduated processes as is the case now - where the process for compulsory treatment can be halted by the responsible clinician if it is no longer needed.

59. What information should be required for requests to approve the use of compulsory mental health treatment?

Clinical history, Current presentation, Risk assessment, input from the person concerned, their family/whānau/significant others.

63. What should the process be when a person disagrees with the compulsory mental health treatment chosen for them by a health practitioner?

Same process as under the current MHA - request judicial review as

soon as practicable.

64. Under what circumstances should a health practitioner be able to override a person's decision about a particular treatment if the person is under compulsory treatment?

Where the person's decision is based on their delusional process, has not been fully understood, or has been informed by misinformation. That being said, best practice would be for the practitioner to discuss their particular requests for certain treatments and if they are not contraindicated then allow them to be used.█

65. What role, if any, should police have in the new legislation?

The police are required to maintain public safety. They have their own powers to detain when needed. They will probably still be needed to assist health practitioners where a person of concern is acting in a dangerous manner, and to assist with secure transport to a place of assessment.

66. What monitoring and oversight roles should be created in new legislation?

Currently there is the Mental Health Review Tribunal, Director of Mental Health, District Inspector, Director of Area Mental Health Services. I think these are still appropriate, but perhaps included in the process for District Inspector to consult with family/whānau and consumer advisor if they conduct an investigation.

67. What should be the powers and responsibilities of these roles?

As per current MHA.

68. What should be the complaints process for compulsory mental health treatment?

As per current internal complaints, HDC and District Inspector.

69. Do you have anything else that you would like to share to help shape mental health legislation in Aotearoa New Zealand?

We would like to stress the importance of resource provision for people requiring compulsory assessment and treatment because they pose a risk to themselves or others. There needs to be excellent mental health care provided by highly qualified mental health practitioners in order to safely validate such requirements imposed by legislation. These practitioners must be appropriately resourced and staffing levels must be mandated.

Finally we note that the importance of resource provision is also highlighted by the consultation response from the New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi. We wish to express support for the general tenor of their overall submission.