Mental Health Foundation OF NEW ZEALAND
*mauri tū, mauri ora*

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Whakaitia te Whakawhiu i te Tangata

19 May 2021

Dear Health Committee

**Mental Health (Compulsory Assessment and Treatment) Amendment Bill**

Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora
He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora Hinengaro

## Introduction

Thank you for the opportunity to comment on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill ('the Bill').

This is a joint submission from the Mental Health Foundation of New Zealand and the Like Minds Like Mine Nōku te Ao programme (see pages 10-11 for a description). It includes feedback from people with lived experience of mental distress or illness/tāngata whaiora and of being subjected to compulsory assessment and treatment under the Mental Health Act ('the Act').

**We are generally supportive of the intentions of the Bill to improve the protection of individual rights, the safety of patients and the public and enable more effective application of the Act.** We appreciate this Bill is a positive first step towards the broader work to repeal and replace the Act.

For us, and so many in the sector, we are eager to see the repeal and replacement of the Act get underway. The public discussion about beliefs, evidence and attitudes about mental health and risk is a vital part of this work. Two years on from the Government's agreement to repeal and replace the Act as part of its response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*, we continue to advocate for a long-term plan to implement all 38 recommendations accepted or supported in principle by the Government, including the repeal and replacement of the Act.



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Lived experience groups, in particular, are still waiting to hear how they can participate in this review process and inform the outcomes of legislative change.

Through our consultation with tāngata whaiora, some tell us they feel these initial changes may soon be redundant if there is to be an entirely new legislative framework that include fundamental shifts in our approach to mental health legislation. Others talk about a sense of frustration that work on this Bill is distracting from the broader repeal and replacement work, further delaying the substantive work and reducing the likelihood of significant progress during this term of government.

These concerns appear to be borne out in the Cabinet paper recommendation to 'defer public consultation on repealing and replacing the Mental Health Act until the legislative process for initial amendments is completed'. This approach is at major odds with the general attitude of the sector and the lived experience community. Many feel a real sense of urgency to replace the Act with a framework that is grounded in human rights and Te Tiriti o Waitangi principles, aligned with recovery and social wellbeing models of mental health in a way that is mana-enhancing and person-centric. They want an immediate end to the continued and unacceptably high rates of coercion under the Act, and the variation and disparities in rates of compulsory treatment, seclusion and restraint experienced particularly by Māori.[1]

Finally, people with lived experience told us they were disappointed the Bill did not seek to eliminate seclusion practices in mental health and addiction settings, which pose no therapeutic benefit and breach human rights.

**Eliminate indefinite treatment orders (clauses 7 and 8)**

We endorse the abolition of indefinite compulsory treatment orders under the Act and are pleased to see the repeal of the current section 34(4) which provides that a compulsory treatment order that is further extended after a six month extension is extended indefinitely.

[1] Health and Disability Commissioner. (June 2020). *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner.*

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We understand the Bill is replacing indefinite treatment orders with a requirement for independent review of compulsory status by the court at 12 month intervals. We note this amendment largely represents a bureaucratic change rather than a practical one - tāngata whaiora will still be subjected to long-term treatment orders, potentially for decades, where they are deemed not fit to be released from compulsory status by the Courts. We believe a significant driver of indefinite compulsory treatment orders is a risk-averse mental health system and a paternalistic belief by some clinicians that compulsory treatment is necessary to ensure treatment compliance and avoid relapse of severe mental distress. A significant system and culture change is therefore still required to reduce the number of long-term compulsory treatment orders going forward.

However, as an immediate first step, we support the mandatory review of an extension and examination by a District Court Judge as outlined in the Bill. From a human rights perspective the availability and accessibility of regular, independent review processes is crucial.[2] It provides a more robust safeguard than appeal processes, as they are not initiated by tāngata whaiora, who may be subject to undue influence or lack of access to resources. Lived experience feedback we have received on the Bill raised concerns the 12 month time period for review is too long and a shorter period of six months is more in line with a recovery approach.

Given long-term treatment orders will continue, it will be important to ensure there are clear reporting requirements for long-term orders, including the number of people subjected to compulsory status after the first 12 months extension and the length of time they are held under compulsory status, and rigorous monitoring to ensure consistent reporting across District Health Boards (DHBs). Tāngata whaiora will also need to be adequately resourced with legal representation as part of the Court examination and review, in order to exercise their continued right to apply to the Tribunal for a review of their condition.

Through our lived experience consultation, we have also heard about disincentives that may encourage tāngata whaiora to maintain compulsory status. For example, the provision of free or subsidised medication or access to financial supports such as the disability allowance may be an incentive for some to stay under a compulsory treatment order.

[2] Fistein, E.C., Holland, A.J., Clare, I.C.H., & Gunn, M.J. (2009). A comparison of mental health legislation from diverse Commonwealth jurisdictions. International Journal of Law and Psychiatry, 32(3), 147-155.

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Although outside the scope of this Bill, we recommend the Committee direct the Ministry and Minister of Social Development to review the provision of financial and other supports to tāngata whaiora after treatment and during mental health service transitions. Better supporting the financial stability of tāngata whaiora will bring a greater sense of confidence to exit treatment orders and assist in continuing recovery in the community. This should be checked for continuity and consistency around the different regions of Aotearoa.

**Recommendation 1:** Ensure clear and consistent reporting requirements for long-term treatment orders, including the total number by regions, ethnicity, gender, age and the length of time they are in force.

**Recommendation 2:** Ensure tāngata whaiora are adequately resourced with legal representation as part of the Court examination and review.

**Recommendation 3:** Direct the Ministry and Minister of Social Development to review the provision of financial and other supports to tāngata whaiora after treatment and during mental health service transitions.

**Recommendation 4:** Note the significant system and culture change still required to reduce the number of long-term compulsory treatment orders.

**Minimise the risk of harm to the patient or the public when transporting forensic patients who are special patients as defined under the Act (clauses 9 and 11)**

This amendment appears to allow for government agency staff such as corrections officers, police officers and DHB staff, to transport special patients using the 'safest transportation environment for an individual'. We understand some agencies are reluctant to assist with transport because the current Act does not permit the use of force when transporting these patients. The Cabinet paper notes 'recent incidents have highlighted the need for a legislative change' but is not clear how many incidents have occurred or the risks these incidents posed to individual and public safety. It is therefore difficult to judge whether this proposed change is proportionate to the potential risks involved in the transport of special patients.

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We heard opposition to this provision on the Bill from people with lived experience. They note:

- The amendment contradicts the intentions and efforts to develop new mental health legislation in accordance with human and disability rights principles and the related instruments of the United Nations, such as the UN Convention of the Rights of People with Disabilities.
- There is evidence under the Act that practitioners are either unable or unwilling to consider the least restrictive course of action in similar circumstances, and often people are restrained and secluded in solitary confinement in an arbitrary fashion, or based on prejudice, discrimination, unconscious bias or individual and institutional racism.

Ultimately, the powers proposed by the Bill pose a risk that excessive use of force may be used, at times, in the transport of special patients. We also question the suitability of employing police and corrections officers in the transport of special patients. Not all special patients are 'criminals' (i.e., they may have been charged but not convicted of an offence) and corrections and police officers may not have the right skills or training to work with special patients within a health setting.

Therefore, in addition to an agreed transport management plan, we recommend additional safeguards in the legislation or related guidelines, including more clearly defining or providing examples about what 'reasonably necessary in the circumstances' means in the context of use of force in respect of a special patient; mandatory mental health training for all staff involved in the transport of special patients; mandatory recording of body cameras on transport staff; and accompaniment by a peer support worker or other support person during transportation.

**Recommendation 5:** Include additional safeguards to protect against possible abuse of powers when transporting special patients, such as clearly defining 'reasonably necessary', mandatory mental health training, recording of body cameras on transport staff, and peer or other support staff to accompany a special patient during transportation.

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**Family member or caregiver of the proposed patient, or another person concerned with the welfare of the proposed patient, to be present by audio or visual link (clause 5)**

We agree this is a pragmatic and helpful amendment. We can see advantages if this type of flexibility could be encouraged during consultation with whānau/family about assessment and treatment events under the Act. National whānau consultation rates typically sit at around 60-65%[3] and consistently the most common reason for services not consulting whānau was that it is not practical. The option of consulting by phone or video technology may help to make consultation a more practical exercise for providers.

**Recommendation 6:** Direct the Ministry of Health to explore how audio-visual technology might also be used to increase rates of consultation with whānau/family about assessment and treatment events under the Act.

**Part 2: Amendments relating to COVID-19**

**Clause 15 Section 6A amended (use of audiovisual links permitted during COVID-19 response)**

We object to the wholesale changes made by the *COVID-19 Response (Further Management Measures) Legislation Act 2020* being made permanent without the presentation of robust evidence these changes are a) necessary to the application of the Act outside of a pandemic and b) will not lead to unintended, negative outcomes for tāngata whaiora.

In 2020, Platform Trust, MHF and Balance Aotearoa raised concerns about the proposed changes to the Act as part of the *COVID-19 Response (Further Management Measures) Legislation Bill*. At the time we absolutely acknowledged the containment of COVID-19 was the most important factor and supported the Bill. We argued for and were pleased to see the addition of the sunset clause, ceasing the existence of these powers once the need was over. This is because we believe there are potential risks about the diagnostic efficacy and cultural appropriateness (i.e., it could disadvantage Māori and other ethnic groups that rely on interpersonal connectedness and whanaungatanga) of using audio-visual technology for mental health assessments and examinations.

[3] Ministry of Health. 2021. Office of the Director of Mental Health and Addiction Services Annual Report 2018 and 2019. Wellington: Ministry of Health.

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The MHF and the Nōku te Ao Like Minds programme are of the view that potential risks of using audio-visual link technology remain, including technology not being suitable for some people such as older people, people with other neurological disabilities, and those experiencing severe mental distress; that people may have limited access to technology, privacy concerns, and the potential to misinterpret non-verbal communication leading to inaccurate diagnoses. We can also see there may be practical benefits to using audio-visual links, including enabling people to access services in their own personal environment. We think it would be prudent for the select committee to be assured the potential benefits of using audio-visual technology outweigh the potential risks. We understand there is little published evidence about the benefits and risks of using this technology specifically for psychiatric assessments and examinations, although there is more evidence about the use of technology-based interventions and treatment, and we also understand the majority of these studies represent the views of clinicians and service providers rather than the experiences of tāngata whaiora.

We also note the cabinet paper states the 'Ministry of Health has received many reports from Directors of Area Mental Health Services and district inspectors that the use of audio-visual link technology has been very beneficial for some 'patients'. We would encourage the select committee to also hear directly from tāngata whaiora about the benefits or otherwise they perceive with these changes.

If clause 15 of the Bill is accepted, we believe the Ministry's Advice on compulsory assessment and treatment processes for mental health services during COVID-19 Alert Level 2 should be incorporated into the Guidelines to the Act to support the use of audio-visual link technology. In particular, we support and would like to emphasise the following principles contained in the COVID-19 Guidelines:

> 3.3. ..." This means that in-person assessment and examination is to be preferred, however, AVL can be used where this is necessary and appropriate."
>
> 3.6. "The use of AVL solely for reasons of convenience or efficiency for service providers is not acceptable."
>
> 3.7. "Greater priority should be given to in-person assessments for the purposes of assessment under assessment sections 8B to 14 of the Mental Health Act, as these relate to decisions that may result in a person being detained or limitations on a patient's rights."

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> 3.8. "The rationale for decisions to use AVL for assessments should be documented and available for review by district inspectors."

Currently the Ministry's COVID-19 Guidelines do not require a person's consent to undertake an assessment by audio-visual link. Outside of a pandemic response, we believe consent should be sought for the use of audio-visual technology. This would be consistent with the Bill's requirement for consent when audio-visual technology links are used to examine a patient at a court hearing (new section 34C). If a person cannot consent (i.e., because they do not have capacity, for example if they are experiencing extreme mental distress) or choose not to give their consent, in-person assessments and examinations must be used.

The advice in the Ministry's COVID-19 Guidelines on refusal to consent is also relevant here:

> 3.11. "A lack of consent...may indicate that the approach will not adequately meet the purposes behind doing the assessment (getting an accurate view of the person's mental health status and risk), which may increase the risk that the assessment could be inaccurate, and the individual could be made subject to the Mental Health Act when this is inappropriate."

**Recommendation 7:** Before making the changes made by the *COVID-19 Response (Further Management Measures) Legislation Act 2020* permanent, ensure the potential benefits of using audio-visual technology for mental health assessments and examinations outweigh the potential risks. The evidence used to make this assessment must include the views and experiences of tāngata whaiora.

**Recommendation 8:** Ask the Ministry of Health what efforts have been made to ask for the view and experiences of tāngata whaiora in their experiences of this change.

**Recommendation 9:** Make publicly available the evidence used to justify the permanency of the changes made by the *COVID-19 Response (Further Management Measures) Legislation Act 2020*.

**Recommendation 10:** Direct the Ministry of Health to incorporate its advice on compulsory assessment and treatment processes for mental health services during COVID-19 Alert Level 2 into the Guidelines to the Act to support the use of audio-visual link technology.

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**Recommendation 11:** Require consent to be sought for the use of audio-visual technology. Where a person is unable to consent or consent is withheld, in-person assessments and examinations must be used.

**New section 34C permits the examination of a patient and the appearance of participants at a hearing by audio-visual link, subject to patient consent, and without examination or hearing, subject to patient consent and other specified conditions (new section 34D).**

We agree it is appropriate to seek consent for the use of audio-visual link technology for the examination of a patient and the appearance of participants at a hearing.

**Summary**

Thank you for the opportunity to comment on this Bill. We believe the Bill provides a step forward for mental health legislation, especially on replacing indefinite treatment orders with an application to the Court to extend a person's placement under the Act every 12 months. We make a number of recommendations to strengthen the proposed changes and protect against unintended consequences, particularly those that impede the human rights of tāngata whaiora.

Mauri tū, mauri ora,

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**About the Mental Health Foundation of New Zealand**

The MHF's vision is for a society where all people flourish. We take a holistic approach to mental health and wellbeing, promoting what we know makes and keeps people mentally well and flourishing, including the reduction of stigma and discrimination (particularly on the basis of mental-health status).

The MHF is committed to ensuring that Te Tiriti o Waitangi and its Articles are honoured, enacted, upheld and incorporated into our work, including through our Māori Development Strategy. We are proud that Sir Mason Durie is a Foundation patron.

The MHF takes a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities, create support and social inclusion for people experiencing distress, and develop positive mental health and wellbeing. Our positive mental health programmes include Farmstrong (for farmers and growers), All Right? (supporting psychosocial recovery in Canterbury, Kaikōura and Hurunui), Pink Shirt Day (challenging bullying by developing positive school, workplace and community environments), Open Minds (encouraging workplaces to start conversations about mental health) and Tāne Ora (working with tāne Māori and their whānau to build wellbeing skills). Our campaigns reach tens of thousands of New Zealanders each week with information to support their wellbeing and help guide them through distress and recovery.

We value the expertise of tāngata whaiora/people with lived experience of mental distress and incorporate these perspectives into all the work we do. Established in 1977, the MHF is a charitable trust, and our work is funded through donations, grants and contract income, including from government.

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**About the Nōku te Ao Like Minds, Like Mine Programme**

Like Minds, Like Mine is a public awareness programme to increase social inclusion and end discrimination towards people with experience of mental illness or distress. We do this through public awareness campaigns, community projects and research.

The Like Minds, Like Mine programme is funded by the New Zealand Government. Te Hiringa Hauora | Health Promotion Agency is the lead operational agency for the programme, with strategic responsibility held by the Ministry of Health.

National coordination and communications for the programme is led by the Mental Health Foundation of New Zealand. The Foundation has a long involvement in the programme, providing support for the national activities for the past decade. It has also held contracts to deliver regional activities.

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