# Submissions on the *Mental Health Act and Human Rights* discussion document – An analysis

**Background**

The Ministry of Health has been leading work to better understand how our mental health legislation relates to our human rights law and obligations under international conventions. The work relates to Action 9(d) of the Disability Action Plan 2014-2018, which is to:

‘Explore how the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) relates to the New Zealand Bill of Rights Act 1990 (NZBORA) and the Convention on the Rights of People with Disabilities (CRPD).’

[The Disability Action Plan 2014–2018](http://www.odi.govt.nz/nz-disability-strategy/disability-action-plan/disability-action-plan-2014-2018-update-2015/), which sets out priorities for action that promote disabled people’s participation and contribution in society, operates under the authority of the Cabinet Social Policy Committee, which provides leadership, coordination and accountability across Government on disability issues.

The Cabinet Social Policy Committee also oversees implementation of the CRPD and the New Zealand Disability Strategy. New Zealand ratified the CRPD in 2008 and acceded to the Optional Protocol on the CRPD in October 2016. In October 2014 the United Nations Committee on the Rights of Persons with Disabilities (the UN Committee) tabled its first review of New Zealand’s implementation of the CRPD. Action 9(d) was included in the 2015 update of the Disability Action Plan in response to the UN Committee’s concerns that the Mental Health Act has been criticised for its lack of human rights principles.

The scope of Action 9(d) addresses issues relating to people who come under the Mental Health Act via the community, rather than those who enter via the criminal justice system. The development of a new forensic framework is the subject of a separate piece of work but will be informed by the work under Action 9(d). Changes to the Mental Health Act are also outside the scope of this work. However, the findings from this exploratory work will inform mental health service and policy development and any future review of the Mental Health Act.

The work has been undertaken in partnership with Balance Aotearoa, a non-Government organisation (NGO) providing peer support to people with mental health and addiction issues, which is one of seven Disabled People’s Organisations mandated to work with Government on the Disability Action Plan. The work has also been informed by a wider stakeholder reference group made up of diverse perspectives, including groups representing tangata whaiora/service users and family/whānau, academics/researchers and services and clinicians (refer Appendix One).

**Summary of feedback on the *Mental Health Act and Human Rights* discussion document**

In late December 2016 the Ministry and Balance Aotearoa released a discussion document, *The Mental Health Act and Human Rights,* for targeted consultation. This was accompanied by an EasyRead companion document. Submissions on the discussion and companion documents were received from the time of their release until late February 2017.

The purpose of the discussion document was to enable interested parties to contribute to a better understanding of the impacts of the Mental Health Act on those who experience it, and to explore the relationship between the Act and our human rights obligations under NZBORA and the CRPD. The document did not put forward options for change.

This summary provides an outline of what we heard.

## The consultation process

The Ministry of Health and Balance Aotearoa conducted a targeted (rather than public) consultation as they were particularly interested in hearing the experiences and perspectives of people who have been treated under the Mental Health Act, family/whānau and those who apply or monitor the Act.

The document was sent to a number of organisations and individuals representing a wide range of perspectives, including:

* NGOs representing people who are and who have been subject to the Mental Health Act (tangata whaiora/service users)
* NGOs representing family/whānau of the above
* clinicians and services who treat service users under the Mental Health Act, including district health boards (DHBs) and NGOs
* academics, researchers and opinion leaders working in the field of mental health law, mental health practice and Maori mental health
* mental health professional associations
* agencies involved in administering or monitoring the Mental Health Act or with an interest in the issues, including the Ministry of Justice, the Office of the Ombudsman, the Human Rights Commission, the Health & Disability Commissioner and the Mental Health Foundation.

A number of these organisations circulated the document to their networks and the Ministry received submissions via that process, including from individual tangata whaiora/service users and family/whānau.

In total, the Ministry received 67 submissions. Of those, there were 40 individuals and 27 groups; 33 of the 67 were from tangata whaiora/service users/families/whānau (both individuals and organisations). The remainder were from a range of professional associations, academics/researchers, clinicians, DHBs/service providers, central Government agencies and quasi-Government organisations including the Office of the Ombudsman, the Health & Disability Commissioner and the Human Rights Commission.

**The eight major themes from the consultation process**

There was considerable consistency across the different perspectives represented in the submissions on the discussion document in relation to the key issues and concerns identified. We have captured these under eight major themes.

1. **Inconsistency of the Mental Health Act with our human rights obligations under the CRPD and NZBORA**

Almost all respondents thought that the Mental Health Act in its current form and aspects of its administration are inconsistent with the CRPD, and with contemporary thinking about mental health and human rights. Notable inconsistencies are the Act’s medical model of mental health (versus the CRPD’s social model of mental health and disability), substituted (versus supported) decision-making and the Act’s lack of recognition of legal capacity.

Many respondents thought that the Mental Health Act is also inconsistent with NZBORA, in the Act’s ability to override a tangata whaiora/service user’s right to refuse medical treatment. The Act was also noted to be inconsistent with the Health and Disability Services Consumers’ Code of Rights’ (HDC Code of Rights) right to informed consent.

The vast majority of respondents thought that the Act could do better in promoting and protecting human rights. Suggestions included:

* Improving tangata whaiora/service user and family/whānau understandings of rights under the Act, the Act process and the Act’s legal safeguards, and other protections such as the Health and Disability Advocacy Service. This could occur via better communication with tangata whaiora/service users and their family/whānau, better access to interpreters, promoting greater understanding of the role of District Inspectors and access to legal and other documentation in easy-to-read formats.
* Strengthening of the Act’s safeguards, including resourcing and training of District Inspectors, the usefulness of the Mental Health Review Tribunal (which was observed to often favour the clinicians’ evidence at the expense of the tangata whaiora/service user’s evidence), timeliness of section 16 hearings and the introduction of compulsory judicial reviews of tangata whaiora/service users subject to indefinite compulsory treatment orders (CTOs).
* ‘Humanising’ the Act process, which is experienced by many tangata whaiora/service users and their family/whānau as medicalised and paternalistic. This is often to the detriment of the therapeutic relationship and the tangata whaiora/service user and their family/whānau’s sense of hope and self-determination.
* A shift towards a more collaborative approach to decision-making with tangata whaiora/service users and their family/whānau, including better access to independent advocacy, peer support, legally binding advance directives.
* Improving services’ cultural responsiveness in the context of the Act’s ‘cultural blindness’, its disproportionate application to Māori and Pasifika, variable cultural competency on the part of clinicians, variable access to culturally appropriate services and the increasingly culturally diverse New Zealand population.
* A more transparent second opinion process (sections 59 and 60 of the Act), including the involvement of independent advocates and a publicly available list of clinicians authorised by the Mental Health Review Tribunal to provide those opinions. Ideally, tangata whaiora/service users would be able to choose a clinician from that list.
* Urgent action to eliminate the use of seclusion and restraint.

A number of respondents (around a quarter) called for a review and/or repeal of the Act, ideally using a co-design process, with due consideration given to mitigating any unintended consequences (for example, via increased suicide prevention efforts). Many respondents called for coercion and compulsion to be eliminated, in particular, the use of indefinite compulsory treatment orders (authorised under section 34(4) of the Mental Health Act).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) commented that any review of the Act and how it interfaces with tangata whaiora/service users’ human rights must be considered alongside current societal views and attitudes towards mental illness. RANZCP also said that people living with mental illness continue to experience stigmatisation and discrimination, and that any changes to the Act would need to be supported by a targeted public health strategy to educate the public about the nature of mental illness, the Act and their understanding of rights.

*“The principal impact is the loss of autonomy, which is hugely disempowering. This does not actually aid in assisting mental wellness within patients. Threatening radical options as coercion leads to re-engagement becoming more difficult with services."*

* Affinity Services – Tangata whaiora/service user/family/whānau; NGO perspective

*"[CTOS] create a sense of shame and powerlessness that you can't manage your mental illness and medication independently… [they] give a sense of hopelessness that you are under state care, and that you are legally restricted by the label 'mental patient' and feel marginalised and isolated by that status, and what it implies... [they] can feel more like punishment than treatment, especially as the focus is on the compulsory medication rather than rehabilitation."*

* Individual consumer perspective

*"It affects my confidence and self-esteem. Makes you fearful of mental health services. So you don't tell the truth because you want to get off the Act." "The MH Act makes me nervous of appointments with MH staff. I now don't trust them and wouldn't call them if I needed support."*

* Individual consumer perspective TDHB Mental Health and Addiction Service

 *"There is always the question of whether the Act is used for the person's wellbeing or the convenience of service providers. If a person occasionally chooses to not take their medication which results in them becoming unwell does that justify a legal enforcement of a medication regime?"*

1. **Increase recognition of the views and preferences of tangata whaiora/service users**

Article 12 of the CRPD affirms that people with disabilities have the right to be treated equally before the law. This includes the right to enjoy legal capacity and to access support to exercise their legal capacity. The Act does not recognise legal capacity and is therefore unlikely to be compliant with Article 12, as noted by respondents in Theme 1 above.

This theme elaborates on the extent to which respondents thought that the views and preferences of tangata whaiora/service users are sufficiently taken into account under the Act and what changes should be made.

There was general consensus that at present, tangata whaiora/service users’ views and preferences are not sufficiently taken into account. Tangata whaiora/service users often feel fearful and overwhelmed during their time subject to the Act, and that they are being listened to but not heard.

Many respondents referred to the power imbalance between clinicians and tangata whaiora/service users, and that a tangata whaiora/service user’s autonomy relies on the extent to which they understand their rights under the Act and the Act process. Service users who are less knowledgeable, confident and articulate are disadvantaged in this respect.

There was also general consensus that tangata whaiora/service users (and ideally their family/whānau) should be fully involved in the decision-making process wherever possible. Suggestions included:

* The development of sector guidance on collaborative decision-making and continual assessment of a tangata whaiora/service user’s capacity for understanding relevant issues related to their mental health treatment and capacity to consent to treatment.
* Involvement of tangata whaiora/service users and their family/whānau at multi-disciplinary team meetings.
* Better access to peer support, advance directives, District Inspectors, cultural advisors and independent advocates. (District Inspectors are reminded that they are not advocates, but are often asked to seek leave or changes to treatment plans on a tangata whaiora/service user's behalf. Advocates are often not independent.)
* Greater visibility of and investment in the Health and Disability Advocacy Service. Ideally, advocates would be proactively providing services to tangata whaiora/service users.
* Easy-to-read information on the Act in multiple languages.
* Better access to interpreters, including New Zealand Sign Language interpreters.
* Workforce development to support responsible clinicians to engage in more collaborative planning with tangata whaiora/service users and their family/whānau. For example, at present the system does not support tangata whaiora/service users’ choice of lawyers, nor match of tangata whaiora/service user need and lawyer expertise.

**Informed consent**

Many respondents commented on ‘consent’ under section 59 of the Act. Tangata whaiora/service users are often surprised to hear that they have the right to withdraw ‘consent’ to medication after the one month compulsory assessment period, and find it difficult to understand the notion of 'consent' when a CTO has already been imposed.[[1]](#footnote-1) Suggestions included:

* Amendments to the Act such that ‘consent’ is re-named ‘consultation’, as ‘consent’ under the Act often involves coercion and is therefore not ‘true’ consent. ‘Consent’ could also be replaced with a mandatory second opinion for all tangata whaiora/service users subject to CTOs.
* Workforce development to support clinicians to explain the meaning of ‘consent’ under the Act; this concept is not well understood even by clinicians.
* The seeking of consent to align with the first formal review under the Act (section 76) to give the tangata whaiora/service user and their family/whānau more time to consider, even though this may prolong restrictive treatment. Consent should not be sought before the tangata whaiora/service user has stabilised.
* Amendments to the Act such that the concept of legal capacity is recognised. The Mental Health Commissioner noted that under Right 7(3) of the HDC Code of Rights, tangata whaiora/service users are presumed competent unless there are reasonable grounds for believing they are not. In these circumstances, the tangata whaiora/service user retains their right to informed choices/informed consent to an extent appropriate to their level of competence.
* The Ministry of Health to examine and report on the use of section 59 (as recommended by the Mental Health Commissioner).

*"Consumers’ views need to be validated, listened to and explored to find a solution that will last for them."*

 - Hearing Voices Network Aotearoa – tangata whaiora/service user/family/whānau; NGO perspective

*"Many service users will need the process explained to them several times before they understand it and can participate as equals in the decision making process."*

 - NAMHSCA *–* tangata whaiora/service user/family/whānau; DHB perspective

*"In a rights-based system service users should be fully aware of these rights, which empowers them to knowledgably participate in decision-making around their treatment."*
 - Auckland Disability Law – NGO; Justice sector; Social sector perspective *Peer support is based on mutuality and shared experiences. This style of support contrasts with the traditional paternalistic approach of clinicians and the legal system. Feeling like you have common ground and support from someone fosters the potential for understanding and making choices."*

 - Tangata whaiora/service user/family/whānau perspective

1. **Greater choice in treatment options – not just medication**

Many respondents commented on the limited therapeutic interventions available to tangata whaiora/service users, and the often long waiting lists to receive therapeutic interventions, for example, to see a psychologist. Respondents commented that treatment under the Act predominantly took the form of medication; some with severe side-effects.

Some commented that psychiatrists often have limited time to spend with tangata whaiora/service users on an ongoing basis, and it is therefore difficult for psychiatrists to assess the person’s recovery.

Simply put, tangata whaiora/service users would like more treatment options.

*"We feel there needs to be more treatment choices for the unwell, greater collaboration and more listening."*

- Hearing Voices Network Aotearoa – consumer/family/whānau; NGO perspective

*“An often heard complaint is that insufficient emphasis is put on psychology and too much on medication.”*

- Taranaki DHB Mental Health and Addiction Services

*"The paradox is that if [alternative treatments] were offered within the Mental Health Act or under a CTO, we wouldn't need [CTOs] as people would voluntarily chose to try alternatives or a complimentary biomedical and holistic combination of tools for recovery."*

* Changing Minds – consumer/family/whānau; NGO; service provider perspective

1. **Lack of access to early intervention services seen to be contributing to rates of treatment under the Act**

A number of respondents commented that improved access to early intervention and community services would reduce the need to use the Act. However, they commented that early intervention services currently are neither “robust” nor widely available, leading to greater use of compulsory treatment orders.

 *“It is disappointing to see that sometimes there is no intervention until a crisis occurs and that is difficult for all involved."* - District Inspector perspective

*"Non-coercive processes and the necessary time and space for people to safely work through their angst should reduce the rates of compulsory treatment. It's not the threshold that is the problem. It's the lack of places and processes for distressed people to work things through before they get picked up by the police or mental health crisis services, which tend to wind them up and make coercion inevitable."*

 - Hearing Voices Network Aotearoa New Zealand – tangata whaiora/service user/family/whānau; NGO perspective *"A glimmer of hope that could be built on by a good intervention NOW gets extinguished by waiting months and months for the next step to be available. Mental health issues worsen and get entrenched in these voids in treatment."*

 *-* Tangata whaiora/service user/family/whānau perspective

1. **Conflict between a ‘recovery model’ of mental health and the current culture of risk avoidance/management**

Many respondents thought that fear and risk avoidance are driving a lot of decision-making under the Act. There was a strong view that this culture of fear and risk-avoidance puts tangata whaiora/service user wellbeing and quality of life at risk, as fear of coming under the Act means people may avoid services and compulsion/restrictive practices placed on them often leads to loss of hope. A number of respondents felt that DHBs needed to be more accountable for the variation in the Act’s application between and within DHBs.

Media and public scrutiny was noted to contribute to risk averse cultures within DHBs. Several respondents identified the need for greater support to the media to report on mental health issues in a less sensationalistic and stigmatising way.

RANZCP and some clinicians/service providers thought that the challenge of not operating conservatively is that when things go wrong, the clinician becomes the target. There needs to be greater support from DHBs and the public for clinicians to use the Act in a less coercive, risk averse way.

*"We need to set up protections both for tangata whaiora and their responsible clinicians so that informed, dual responsibility for risk can [be] managed thoughtfully in a trusting space."*

* Changing Minds – consumer/family/whānau; NGO; service provider perspective

*"Criminals are not given sedatives to keep them from causing harm to others when they are released. It seems a fear-based system."*

* Hearing Voices Network Aotearoa – consumer/family/whānau; NGO perspective
1. **Improve family/whānau consultation under the Act**

Few respondents thought that consultation with family/whānau of tangata whaiora/service users subject to the Act was sufficient. This related to both consultation under section 7A of the Act and consultation that occurs outside of this legislative requirement. There was widespread feedback that the knowledge and expertise that family/whānau hold is not given due respect or consideration by clinicians. Consultation was observed to vary significantly across DHBs.

The Act is often initiated in the absence of family/whānau; they may not even be aware that the service user is in hospital. Often, family/whānau have not experienced the Act until it is applied to their family member. It is a time of considerable stress that is exacerbated by the lack of easy-to-read information on the Act and sometimes, the absence of a single point of contact within the tangata whaiora/service user’s clinical team.

Suggestions for improving family/whānau consultation included:

* Consultation with family/whānau at the earliest opportunity in the Act process, including exploration of advance directives, assignment of a family/whānau support worker and/or a referral to Supporting Families in Mental Illness (or similar). This would support family/whānau to navigate the Act process and ideally enable supported decision-making.
* Consultation with family/whānau throughout the Act process; not just at certain junctures. Family/whānau should be made aware that any information supplied may be used in support of a CTO application or at a section 76 review.
* Legal and other documentation in easy-to-read formats, including a glossary of terms commonly used by clinicians, e.g. ‘planning discharge meeting’.
* Continual exploration of family/whānau involvement with tangata whaiora/service users who have declined involvement in the first instance. This was noted to not always happen.
* A review of the Act’s ‘not reasonably practicable’ exception to the need to consult with family whānau. Responsible Clinicians should be required to provide reasons for no consultation and document their efforts to consult.
* Official guidelines on the Act for use by family/whānau and guidelines on family/whānau consultation for use by the sector.
* Inpatient environments that are more family/whānau-friendly, e.g. the availability of designated family/whānau rooms.

Several submissions, particularly those from Māori and Pasifika perspectives, commented on the concepts of ‘principal caregiver’ and ‘family/whānau’. One respondent submitted that the 'principal caregiver' should be expanded to more than one person. This is of particular relevance to Pasifika families, whose ‘aiga’ is both the nuclear and extended family. Other respondents reiterated the importance of the tangata whaiora/service user themselves defining their ‘family/whānau’.

*"Family and whānau are often in a primary caring role. This role and the expertise that family have is, for the most part, unrecognised. Family could be included as part of the team, accepted as 'legitimate care providers', with their input valued."*

 - Supporting Families in Mental Illness NZ – Tangata whaiora/service user/family/whānau; NGO perspective *"Families often tell us about attending meetings with the relevant medical professionals but feeling 'shut out' in a highly medicalised model… They are seeking a more holistic approach to treatment, which would be more culturally appropriate for many."*

 - Auckland Disability Law – NGO; Justice sector; Social sector perspective *Not only was he in crisis but our family was also in crisis…When he is coming home to us and we all live under the same roof, we need to know what's going on! So we can support him. We don't need to know everything, just the main things such as medication, who are the main people we can contact should we have concerns... Take our family concerns seriously."*

 - Tangata whaiora/service user/family/whānau; Pasifika perspective

1. **Strengthen cultural responsiveness, competency and assessment, including kaupapa Māori approaches**

A number of respondents representing the range of perspectives thought that a culturally competent service and cultural assessment is a vital part of tangata whaiora/service user recovery, but this is currently variable across DHBs and services. There were a number of suggestions for how services could be improved:

* Build relationships and have more open, honest and inclusive conversations with tangata whaiora/service users, whānau, aiga and family before a person gets in distress – this is critical.
* A holistic, person-centred approach to treatment is needed.
* Greater acceptance of spiritual concerns and beliefs by services. A couple of respondents commented that the Act and its administration are aligned with Western culture and traditions, for example, the titles given to the different statutory roles under the Act “reinforce the sense of disconnect”.
* Routine use of cultural assessment for all tangata whaiora/service users (this seems to be lacking in many services). Assumptions about a person’s cultural identity should be avoided. For example, a blanket approach to Māori culture and tikanga is not sufficient. Cultural competency and cultural awareness should be a compulsory part of all mental health training. For example, DHBs/services should be using resources like Te Pou o te Whakaaro Nui’s *Let’s Get Real*.
* Māori need to drive, develop, plan and be at decision-making tables - specifically those with the knowledge and communication skills to articulate "tikanga Māori" and Māori worldviews.
* The Māori health workforce is key to improving Māori health outcomes and needs dedicated development and resourcing.
* Prioritise services that are culturally relevant to Māori and Pacific peoples.
* Cultural leaders, advisors and healers should be available in every service and included in multi-disciplinary team meetings (currently an after-thought) and cultural models of health (e.g. Te Whare Tapa Whā, Fonofale) should be adopted and offered to all tangata whaiora/service users as an alternative to or complement to the biomedical model.
* Improve access to culturally appropriate advocacy services after hours.

*"We believe that everyone has a culture that they identify with. [Culture] is more than skin colour, religious beliefs or geographical location."*

 *-* Kites Trust – tangata whaiora/service user/family/whānau; Māori; NGO perspective

*"Māori and Pacific understandings of mental health and wellbeing are universally more holistic, person centered and family/whānau focused. When cultural assessment... and practice is applied… coercion and seclusion reduces significantly.”*

 *-* Changing Minds – tangata whaiora/service user/family/whānau; NGO; service provider perspective

1. **Give greater priority to reducing and eliminating seclusion** **and restraint**

There was general support from respondents for the work being done with DHBs to reduce the use of seclusion and restraint.

Some respondents thought that the Ministry of Health should impose a deadline for eliminating seclusion rather than leave it to DHBs.

RANZCP strongly encouraged the Ministry to implement a research plan to develop new interventions or practice approaches based on sound evidence that underpin their design and implementation. RANZCP emphasised the need to review the systems and processes leading up to seclusion. They acknowledged the work already undertaken by Te Pou o te Whakaaro Nui and the Human Rights Commission, and suggested further training and education for services as part of the solution to reducing seclusion and restraint.

The Mental Health Commissioner emphasised the importance of tangata whaiora/service users under the Act knowing their rights under the HDC Code of Rights and the Act, and being able to exercise those rights. The Mental Health Commissioner said it would like to work with the Ministry and services to respond to any areas for improvement identified by this project to increase tangata whaiora/service user awareness of their rights under the HDC Code of Rights.

 *"Isolating, almost like a punishment? What other options are there rather than seclusion??"*

* Individual consumer; Pasifika perspective

*"Seclusion and restraint has a wide-reaching effect. Patients and clinical staff are constantly on edge… It is a highly reactive situation for both staff and patients. Open the wards, and offer better support within the community."*

* Affinity Services - Consumer/family/whānau; NGO

*"We believe it will be difficult to modify attitudes around current practices if there is poor understanding regarding alternative approaches to restraint and seclusion or a lack of knowledge about when it may be permissible to use these techniques."*

* The Royal Australian & New Zealand College of Psychiatrists

## Key themes of the guidance provided by the Reference Group

The key issues/concerns identified by the Reference Group in August 2016, prior to the targeted consultation process, were consistent with those that emerged through the targeted consultation on the discussion document.

* For many, the experience of coming under the Act is negative, stigmatising and disempowering, although some experience it as a relief/safety net.
* There needs to be greater recognition of capacity and the right to consent in legislation, policy and practice.
* There is a need for more advocacy and support for tangata whaiora/service user decision-making and more collaborative care planning, beginning at the early intervention stage. Links between primary care and secondary mental health services should be strengthened.
* Tangata whaiora/service users need greater choice in treatment – not just medication.
* The current risk management paradigm does not promote recovery and needs to change.
* Resourcing and access to services is problematic and is a barrier to introducing greater autonomy into the Act environment.
* There is need to strengthen kaupapa Māori approaches within mental health, including a greater role for whānau and an expanded Māori health workforce.
* There is a need to strengthen checks and balances in parts of the mental health system such as: promoting the role of District Inspectors; greater use of advance directives; improving access to independent advocates; better information about the Act’s processes; greater support for tangata whaiora/service users to challenge decisions under the Act; greater valuing by Courts and the Mental Health Review Tribunal of tangata whaiora/service user and family/whānau views and a greater focus on treatment outcomes; and strengthening of the requirements around informed consent and second opinions.
* Give greater priority to eliminating the use of seclusion and restraint.
* The need to address the variability in practice under the Act around the country – this is a quality issue.

## Putting the messages from consultation to good use

We took the following approach to using messages from the consultation:

* All input from the consultation with stakeholders and from the Reference Group meetings has been analysed.
* The feedback and findings will be a key input to:
	+ The Ministry’s advice to the Ministerial Committee on Disability Issues in relation to Action 9(d) of the Disability Action Plan regarding the relationship between the Mental Health Act, the CRPD and NZBORA.
	+ Strategy, policy and service development work currently underway
	+ Ongoing dialogue with tangata whaiora/service users, family/whānau and the mental health sector/services on improving opportunities for people who come under the Act to have a good life like others, and generally improving people’s experiences of the mental health system.
* This report will be available to the public.

**Appendix One: DAP Action 9(d) Reference Group members**

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| --- | --- |
| Taimi Allan  | CEO, Changing Minds  |
| David Codyre  | Community/primary care psychiatrist, East Tamaki Health Care and National Telehealth Service |
| Grant Cooper  | Ngā Hau E Wha (national consumer advisory group) member and Manager, Otago Mental Health Support Trust  |
| John Dawson  | Professor, Faculty of Law, University of Otago (specialist area is mental health law)  |
| Cassandra Laskey  | Professional Leader, Consumer and Family/Whānau Centred Care in Mental Health, Counties Manukau DHB   |
| Mary O'Hagan  | Developer and Director of Peer Zone, co-ordinator of Peer Zone international consultancy |
| Peter O’Kane  | Senior Mental Health Nurse/Duly Authorised Officer at Capital and Coast DHB |
| Joyce McDonald Leevard  | Youth consumer advisor at Counties Manukau DHB  |
| Vito Nonumalo  | Service User Lead at Emerge Aotearoa  |
| Fiona Perry  | National Co-ordinator, Supporting Families in Mental Illness NZ Inc. |
| Dean Rangihuna  | Te Kaihapai/Māori consumer Advisor, Canterbury DHB |
| Jeremy Skipworth  | Psychiatrist, Clinical Director Mason Clinic, Waitemata DHB  |
| Phyllis Tangitu  | General Manager Māori, Lakes DHB (particular interest in mental health)  |
| Louise Windleborn  | Co-chair of the National Association of Mental Health Services Consumer Advisors (NAMHSCA) and Māori consumer advisor, Hutt Valley DHB  |

1. The Act (section 59(4)) states that the responsible clinician shall, wherever practicable, seek to obtain the consent of the tangata whaiora/service user to any treatment even though that treatment may be authorised by or under the Act without the person’s consent. Under section 63 of the Act, any consent given by the tangata whaiora/service user for the purposes of sections 59 or 60 (or 61) may be withdrawn at any time by the tangata whaiora/service user, and thereafter any further treatment given to the tangata whaiora/service user is deemed to be given without their consent. [↑](#footnote-ref-1)