



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

2022

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These guidelines are not clinical guidelines. They are issued pursuant to section 130(1)(a) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 Act and intended to support the lawful application of the Act, which states that the Director-General of Health may from time-to-time issue guidelines for the purposes of the Act.

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Abbreviations

Amendment Act	Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021
CP(MIP) Act	Criminal Procedure (Mentally Impaired Persons) Act 2003
CRPD	Convention of the Rights of Persons with Disabilities
Code of Rights	Code of Health and Disability Services Consumers' Rights
DAMHS	Director of Area Mental Health Services
DAO	duly authorised officer
DI	district inspector
IPCA	Independent Police Conduct Authority
Mental Health Act	Mental Health (Compulsory Assessment and Treatment) Act 1992
NZBORA	New Zealand Bill of Rights Act 1992
RANZCP	Royal Australian and New Zealand College of Psychiatrists
Review Tribunal	Mental Health Review Tribunal
SOGIESC	sexual orientation, gender identity and expression, or sex characteristics
SPEC	Safe Practice Effective Communication
Substance Addiction Act	Substance Addiction (Compulsory Assessment and Treatment) Act 2017
UNCROC	United Nations Convention on the Rights of the Child

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Introduction

These *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* ('guidelines') support the effective and lawful use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 ('the Act' or 'the Mental Health Act'). They are written mainly for clinical staff, district inspectors and any other parties who administer or work within the legal or clinical framework of the Mental Health Act. Families and whānau, service users and tāngata whai ora, and members of the public may also find these guidelines useful.

We last updated these guidelines in 2020. Key changes and emerging issues that have prompted us to revise these guidelines are:

- the growing influence of rights-based approaches and how these can be better promoted within the parameters of the current Mental Health Act. For a detailed discussion of this subject, see the companion document to these guidelines, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*
- the need to give greater emphasis to our obligations under Te Tiriti o Waitangi
- the impact of the Government Inquiry into Mental Health and Addiction, He Ara Oranga, particularly through feedback from people with lived experience and their families and whānau on how they experience current administration of the Act.
- updates with regard to the passing of the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021 (MH(CAT) Amendment Act 2021).

Because some of the emerging issues are beyond the intent and purpose of these guidelines, we will address them in later publications. Feedback from the various consultation groups also included requests for more clinical guidance in some sections, which the Manatū Hauora Ministry of Health ('the Ministry') intends to respond to by developing such guidance separately and/or endorsing existing clinical guidelines.

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

The Mental Health Act provides a legal framework and sets out the narrow circumstances in which people may be subject to compulsory (psychiatric) assessment and treatment. It should be thought of as part of a wider model of care involving services for people experiencing a mental disorder (as defined by the Act) who are unwilling or unable to consent to voluntary treatment, in situations where these people may cause serious harm to themselves or others and are gravely impaired in caring for themselves. Compulsory treatment under the Act aims to provide an opportunity for a person experiencing a serious mental disorder to receive treatment to enable them to live well in the community and regain self-determination for their health care.

The Mental Health Act promotes the principle of least restrictive intervention through its focus on: regular consultation between clinicians and patients, their family, whānau, legal guardians, principal caregivers or significant support network; good clinical practice; and an approach that favours community treatment over inpatient care, where possible.

Balancing individual rights with professional and legal duties

The Mental Health Act has evolved as an interface between medical treatment and legal intervention. In contrast, the rights in international law, such as the United Nations Convention of the Rights of Persons with Disabilities (CRPD), are not directly enforceable through the courts unless they are enacted into our domestic law. However, many of the CRPD rights are affirmed through the New Zealand Bill of Rights Act 1992 (NZBORA), the Human Rights Act 1993 and the Code of Health and Disability Services Consumers' Rights (the Code of Rights) and there is an expectation that health practitioners will operate within the bounds of these Acts and Code of Rights as much as possible.

Clinicians must consider the balance between these interests and apply professional and ethical principles when using the Mental Health Act. Consistent with the NZBORA and with the intent of the Mental Health Act, they should provide treatment in the least restrictive way possible. Please also read the companion document to these guidelines, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*, which offers guidance to thinking about and applying a human rights approach and supported decision-making when implementing the Act.

No legislation can be framed in a way to precisely cover all circumstances that could possibly arise. If someone is facing a decision about which one of two available interpretations to adopt, the purpose of the action can influence that choice, but they must follow the statutory text as good intentions do not permit actions that are otherwise unlawful. It is important in these situations to apply both a legal and an ethical framework. Interpreters should consider, within the statutory requirements, whether the action:

- is in the best interests of the patient
- is necessary to protect the health and safety of the patient, and others
- meets legislative requirements and aligns with the intent of the legislation
- upholds the rights of the patient and others to the maximum extent possible in the circumstances.

Challenges with the term ‘patient’

Many people around Aotearoa New Zealand disagree with using the terms ‘patient’ and ‘proposed patient’. This view is understandable because such terms can reflect a stigmatisation of people who experience mental illness, such that they are at risk of being recognised and treated as people who are managed through medical treatment, rather than as individuals with choices and autonomy. Preferred terms may include ‘consumer’, ‘service user’ or ‘tangata whai ora’.¹ Under the Act, ‘patient’ and ‘proposed patient’ each have a specific legal meaning, so we use them for the purposes of these guidelines.

Additional guidance

Appendix 1 lists related Ministry of Health and other publications and recommended readings.

¹ ‘Tangata whai ora’ means ‘the person who is seeking wellness’.

1 Te Tiriti o Waitangi – the Treaty of Waitangi

This chapter sets expectations and outlines how clinicians applying the Mental Health Act can align their practice with Aotearoa New Zealand’s founding document between Māori and the Crown, Te Tiriti o Waitangi – the Treaty of Waitangi.

Sections 4, 5 and 65 of the Mental Health Act set out the statutory obligation to include cultural considerations for processes and decisions under the Act, including proper recognition that the patient’s ties with whānau, hapū and iwi are important to the patient’s wellbeing. These revised guidelines underline the importance of meeting obligations under Te Tiriti o Waitangi.

The Ministry of Health, as steward and kaitiaki of the health and disability system (Article I of Te Tiriti), has a responsibility to enable Māori to exercise authority over their health and wellbeing (Article II), to achieve equitable health outcomes for Māori (Article III), in ways that enable Māori to live, thrive and flourish as Māori (the Ritenga Māori Declaration).² Under Te Tiriti o Waitangi, the Ministry and all publicly funded health services are obliged to acknowledge and apply Te Tiriti o Waitangi articles and principles in their policies and practices.

In 2016, the Waitangi Tribunal began the Health Services and Outcomes Kaupapa Inquiry (Wai 2575) into nationally significant health issues for Māori. Stage One focused on claims relating to the primary health care system, making substantial recommendations for change in a report released in 2019.³ Stage Two of Wai 2575 will investigate themes of national significance relating to mental health, disabilities, issues of alcohol, tobacco, and substance misuse; the findings and recommendations may impact future editions of these guidelines. Stage Three will cover remaining nationally significant and eligible historical issues.⁴

The Waitangi Tribunal found the following Te Tiriti o Waitangi principles applied to its inquiry. These principles are reflected in the Ministry of Health’s *Whakamaau: Māori Health Action Plan 2020–2025*.⁵

² The Ritenga Māori Declaration (often referred to as the ‘fourth article’) was drafted in te reo Māori and read out during discussions with rangatira about Te Tiriti o Waitangi. It provides for the protection of religious freedom and the protection of traditional spirituality and knowledge.

³ Waitangi Tribunal. 2019. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. Wellington: Legislation Direct.

⁴ For more information and guidance about the Health Services and Outcomes Inquiry, including the 2019 report on Stage One, go to <https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/>

⁵ Ministry of Health. 2020. *Whakamaau: Māori Health Action Plan 2020–2025*. Wellington: Ministry of Health.

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

Te Tiriti principles are interrelated and aim to strengthen effective health pathways, equitable outcomes and overall satisfaction within the health and disability system for all. We see that Māori continue to be disproportionately placed under the Mental Health Act, receiving community compulsory treatment orders under the Act at four times the rate of non-Māori, per 100,000 population.⁶ Government agencies, organisations and sectors must work together to improve health outcomes, as it is the responsibility of all people living in Aotearoa New Zealand to be actively fulfilling the agreements made between the Crown and Māori.

In 2020, the Ministry of Health finalised *Whakamaua: Māori Health Action Plan 2020–2025* (Whakamaua). Whakamaua gives practical effect and monitoring to He Korowai Oranga: the Māori Health Strategy, which was refreshed in 2014 with the overarching vision of **pae ora** – healthy futures for Māori. Pae ora encompasses three elements: whānau ora (healthy families); mauri ora (healthy individuals); and wai ora (healthy environments). The Ministry envisions that we will achieve pae ora through meeting our obligations under Te Tiriti o Waitangi and putting into action the principles of Te Tiriti o Waitangi listed above.

⁶ Moreover, Māori receive inpatient compulsory treatment orders at 3.7 times the rate of non-Māori. Ministry of Health. 2019. *Office of the Director of Mental Health and Addiction Services Annual Report 2017*. Wellington: Ministry of Health.

Whakamaua outlines a suite of actions, priority areas, objectives and outcomes that the Crown and health and disability sector can adopt to achieve the best outcomes and healthy futures for Māori. The following are the four intended high-level outcomes of Whakamaua.

1. Iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing.
2. The health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
3. The health and disability system addresses racism and discrimination in all forms.
4. The entire health and disability system includes and protects mātauranga Māori.

The four objectives that we will use to monitor progress towards these outcomes over the five-year period are to:

1. accelerate the spread and delivery of kaupapa Māori and whānau-centred services
2. shift cultural and social norms
3. reduce health inequities and health loss for Māori
4. strengthen system accountability settings.⁷

We encourage the Crown and health and disability sector to adopt Whakamaua in their business planning and in meeting their statutory objectives and functions for hauora Māori. For more information about Whakamaua and its strategy and tools, visit the Ministry of Health website (www.health.govt.nz) and search for 'Whakamaua'.

⁷ See 'Monitoring', *Whakamaua*, pages 52–58.

2 Section 2: Interpretation

2.1 ‘Mental disorder’

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

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

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

and **mentally disordered**, in relation to any such person, has a corresponding meaning.⁸

The interpretation of ‘mental disorder’ has two ‘limbs’. First, a person must be assessed as having an ‘abnormal state of mind (whether of a continuous or intermittent nature), characterised by delusions, disorders of mood, perception volition (ability to make choices) or cognition (understanding)’. Second, the ‘abnormal state of mind’ must be ‘of such a degree that it –

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

A mental health practitioner may certify a person for compulsory assessment when they have ‘reasonable grounds to believe’ that the person is ‘mentally disordered’. A judge may make a compulsory treatment order for a person who is ‘mentally disordered’ if the judge ‘having regard to all the circumstances considers it necessary to make a compulsory treatment order’ (section 27). A person may remain under compulsory treatment for as long as they are ‘mentally disordered’. If they cease to meet the definition of ‘mental disorder’, they have the right to be released (see 2.2: ‘Fit to be released from compulsory status’ below).

⁸ ‘Mental disorder’ in Section 2: Interpretation of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The Mental Health Act applies only to those people with mental disorder who satisfy the two-limb definition above. The first limb requires the presence of an 'abnormal' state of mind, either continuously or intermittently, and the second requires that the presence of that state of mind causes consequences of a certain severity. No-one can be subject to an assessment or treatment order based on having an 'abnormal state of mind' alone.

A person cannot be subject to the Mental Health Act solely on the basis of their intellectual disability, substance use, personal, political or religious beliefs, or criminal or delinquent behaviour (section 4 of the Act). People who are under the Mental Health Act may have an intellectual disability or an acquired brain injury or may use substances, but they must first meet the two-limb definition of mental disorder.

The central criterion for initiating and continuing compulsory assessment and treatment is that a person is, or appears to be, **mentally disordered**. The Court of Appeal discussed the definition of 'mental disorder' at length in its decision in *Waitemata Health v Attorney-General*.⁹ It made the following general points in that case.

- The definition of 'mental disorder' is based on phenomena rather than diagnosis.¹⁰ The Mental Health Act avoids reference to any particular mental or psychiatric illness. Instead, it provides a number of symptom clusters that might indicate an 'abnormal state of mind'. These clusters are 'delusions, or disorders of mood or perception or volition or cognition'.
- The language of the 'mental disorder' definition seeks to avoid the debate over the difference between mental illness and behavioural disorders. A person with a severe personality disorder exhibiting any of the phenomena identified in the 'mental disorder' definition may well qualify for compulsory treatment under the Mental Health Act.

2.1.1 'Abnormal state of mind'

An 'abnormal state of mind' is determined wholly by the presence of one or more of the phenomena provided in the 'mental disorder' definition. Clinicians must not measure whether a person has an objectively abnormal state of mind compared with that of the average person, but whether any phenomena (as described in 2.1.3: 'Characterised by delusions, or by disorders of mood or perception or volition or cognition') that indicate an abnormal state of mind are present.

⁹ *Waitemata Health v Attorney-General* (2001) 21 FRNZ 216; [2001] NZFLR 1122.

¹⁰ 'Phenomena' are abnormalities of specific areas of mental functioning (psychopathology) that may be observed. The presence of individual abnormal phenomena does not necessarily indicate a specific illness or diagnosis. 'Diagnosis' is an attempt to identify an illness, based not only on the presence of patterns of psychopathological abnormalities, but also on the basis of the cause (aetiology), time course (history) and outcome (prognosis) of the disorder. Diagnosis may be relevant to the definition in terms of assessing whether the disorder of mind is of a continuous or intermittent nature (See: Dawson J. 1996. Psychopathology and civil commitment criteria. *Medical Law Review* 4: 62–83.)

2.1.2 'Whether of a continuous or an intermittent nature'

The definition of 'mental disorder' specifically includes intermittent disorders, to allow for a fluctuating intensity of the phenomena characterising an abnormal state of mind. Remission and relapse of phenomena may occur during a person's recovery. To meet the definition of mental disorder, however, a causative link between abnormality of mind and the second limb of the definition must be established.¹¹

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

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

To avoid over-applying the Act, a person should only be subject to compulsory treatment on an ongoing basis when there is a reasonable clinical determination, based on prior history, that a person's condition will meet the two limbs of the Act. Clinicians should make every effort to take a supported decision-making approach to give the person the opportunity to determine how they would like to be cared for. This means consulting with the person and seeking their views about the most appropriate approach to their treatment, during periods when they are well and/or have capacity to make their own decisions.

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

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

¹¹ NZMHRT 17/059, 3 July 2017.

Particular care must also be taken to establish that the state of mind is 'abnormal' in terms of the individual's cultural norms, including their religious or spiritual belief systems. For example, in *MMG*,¹² consider the discussion of the applicant's beliefs in witchcraft and membership with a community of witches, which included the applicant's mother.

Several phenomena that feature in the mental disorder definition – delusions, disorders of mood and disorders of perception – are well-defined clinical concepts. The Court of Appeal in *Waitemata Health* made passing mention of the phenomena in the definition of 'mental disorder', describing them as words in ordinary use, although their application depends heavily on the assessment of clinicians. This means that colloquial uses of those words are not sufficient to bring someone under the Act, but that phenomena are not strictly limited to their clinical definitions. For example, if a person is described as 'deluded' in a colloquial sense, it does not follow that the person has 'delusions' for the purposes of the Act. However, the Court suggested that a severe personality disorder that led to an exceptionally disturbed view of the world could feasibly be taken to be a disorder of cognition or perception.¹³

This interpretation has been applied in some later cases,¹⁴ but questioned in others.¹⁵ Note that the 'mental disorder' definition was not directly at issue in the *Waitemata Health* case, and so the Court's statements are advisory rather than strictly binding. The Ministry sees the law in this area as unsettled, and cautions against undue expansion of the psychiatric understanding of the disorders that can give rise to an abnormal state of mind. Further, the concepts of 'disorder of volition' and 'disorder of cognition' are not well defined clinically and are open to interpretation. The following explanations provide guidance in this area.

Disorders of volition

'Volition' means the power to consciously choose or will, and includes the power to act on or abstain from acting on that choice or will.¹⁶ A disorder of volition may include:

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

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

¹² *MMG*, NZMHRT 568/98, 18 November 1998.

¹³ *Waitemata Health*, above note 9, at [72].

¹⁴ For example, in a later case concerning Mr H (*Re RCH* [2002] NZFLR 413), the Mental Health Review Tribunal accepted the view that H's severe personality disorder created overvalued ideas to the extent that it constituted a disorder of cognition. In *Re GTL* (NZMHRT 11/094, 7 December 2011), aspects of a person's severe personality disorder were considered disorders of mood, volition and perception.

¹⁵ *RCH*, NZMHRT 12/039, 30 April 2012.

¹⁶ Dorland. 2019. *Dorland's Illustrated Medical Dictionary* (33rd ed). The Netherlands: Elsevier; Harris P, Nagy S, Vardaxis N. 2014. *Mosby's Dictionary of Medicine, Nursing and Health Professions: Australian and New Zealand edition* (3rd ed). Chatswood, NSW: Elsevier Australia.

In many different circumstances, volition may be seen as abnormal. These circumstances are within the areas of disorders of impulse control. Here, a person is aware of their actions and potential outcomes of those actions and has normal reality testing, but acts according to an impulse or desire. In *Attorney-General v Mental Health Review Tribunal Northern Region*,¹⁷ it was noted that a disorder of volition can apply to both an irresistible impulse involving loss of free will and a failure to learn to adjust and control impulsive behaviour, provided that the resulting condition is abnormal. It is difficult to judge clinically whether someone is able to resist an urge but chooses not to, or whether they are truly unable to resist; however, the Mental Health Review Tribunal (Review Tribunal) noted that in these situations it is the result that is important. Examples of mental illnesses involving disorders of impulse control include:

- obsessive compulsive disorder
- eating disorders
- impulsive states (for example, in borderline personality disorder or attention deficit disorder)
- kleptomania or pyromania
- pathological gambling.

It is the uncertainty of the group of illnesses listed above that gives rise to one of the largest potential abuses in the definition of mental disorder. Because the term 'disorder of volition' is not generally used in psychiatry, its interpretation is difficult and may result in confusion about how to apply the legal term 'disorder of volition' appropriately to clinical situations. Many psychiatrists believe that obsessive compulsive states and eating disorders may be compulsorily treated if volitional control is reduced. This judgement is still subject to consideration of the second limb of the definition of 'mental disorder'.

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

In general, conditions such as psychosexual disorders and anti-social personality disorder will not be considered an abnormal state of mind, unless particularly severe or complicated by another condition such as a disorder of mood, perception or cognition, delusions or intellectual disability. We address personality disorders in more detail under 'Personality disorder' below.

Mullen explains that of the five specified characteristics of an abnormal state of mind, 'volition' is the one with the least clarity. He describes disturbed volition as not equating simply with disturbed behaviour where that behaviour is freely chosen.¹⁸ For example, paedophilic sexual assaults are not considered reasons for detention under the Act.

¹⁷ *Attorney-General v Mental Health Review Tribunal Northern Region*, HC Auckland M857-SW00, 23 June 2000.

¹⁸ Mullen R. 2013. Chapter 12. In: J Dawson, K Gledhill (eds) *New Zealand's Mental Health Act in Practice*. Wellington: Victoria University Press.

However, clinicians do see disturbances of volition in:

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

Disturbances of volition might also be identified in relation to those disturbances of behaviour, such as self-harm, that are often associated with a personality disorder. However, this involves inferring whether the individual is genuinely choosing their behaviours.¹⁹

Disorders of cognition

‘Cognition’ includes processes of perceiving, knowing, recalling, thinking, learning, evaluating and understanding; and the processes of obtaining, organising and utilising sensory and perceptual information, remembering past experiences, and making plans or strategies.²⁰

Disorders of cognition are typically associated with organic brain dysfunction arising, for example, from drug-related delirium, head injury, severe depression or dementia. They usually involve disruption of the formal mechanisms of thought such as memory, judgement and insight.²¹

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

Disorders of cognition include:

- slowing of cognition in depressive states
- increased rate of cognition in manic states
- disorganisation or disruption of thought process in psychotic states
- cognitive changes (for example, memory, reasoning, judgement or insight) in dementia and other acquired organic mental disorders.

¹⁹ Mullen, above note 18.

²⁰ *Dorland's Illustrated Medical Dictionary and Mosby's Dictionary of Medicine, Nursing and Health Professions*, above note 16.

²¹ JAB, NZMHRT 07/20, 20 March 2007. Abnormal state of mind was characterised by a disorder of cognition, which manifested itself in low global functioning.

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

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

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

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

Personality disorder

Personality disorder is a contentious area for clinicians, academics and the law. Within psychiatry, there is no consensus that personality disorders should be subject to compulsory treatment; the problems that people with personality disorders face are often considered at the margins of what can usefully be considered a mental disorder.²²

Mullen explains that when a person with a personality disorder presents as distressed or threatening, it is not difficult to conclude that they are at greatly increased risk of serious self-harm or harm to others; satisfying the second limb of the test for 'mental disorder'. He adds that it is also usually clear whether they are greatly impaired in their ability to self-care.²³ What is harder, and where clinicians often disagree, is whether such risk or poor self-care is beyond the patient's capacity to manage, and whether compulsory treatment is likely to help.

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

²² Mullen, above note 18.

²³ Mullen, above note 18.

Head injury

A person may be compulsorily treated due to a mental disorder arising from a head injury. As discussed above, the definition of mental disorder under the Mental Health Act is deliberately stated in terms of phenomena rather than diagnosis. The Act requires an abnormal state of mind characterised by one or more phenomena, including 'disorder of cognition'. This applies no matter whether the disorder results from a diagnosis of mental illness (in the narrow sense) or from any other cause, such as traumatic brain injury, hypoxia, toxicity or dementia.

Section 4 of the Act contains the Act's only reference to diagnosis. This specifically excludes certain conditions (such as intellectual disability) as a sole reason for using compulsory assessment procedures. No clause in the Act excludes head injury as the basis of its application.

2.1.4 'Of such a degree that'

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

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

Many judicial and Mental Health Review Tribunal cases have discussed how to determine if someone is a serious danger to self and others. For example, in Case 11/040 the Review Tribunal stated the level of dangerousness can be assessed by taking into account the following considerations.

1. What is the magnitude or gravity of the behaviour concerned?
2. What is the likelihood of the behaviour occurring?
3. What is the proximity of imminence of the behaviour – in other words, how soon or quickly might it occur?
4. What is the frequency of the behaviour – that is, how often might it occur?

In Case 11/040, the Review Tribunal identified some further useful considerations when assessing level of dangerousness:

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

A person need not meet all these criteria at a high level to pose serious danger. The nature and magnitude of their potential harm may be low, but they may exhibit this harm frequently enough to amount to serious danger. For example, the person may be engaging in repetitive harmful behaviour as a result of an abnormal state of mind. Likewise, a person may have committed one or two violent acts as the result of an abnormal state of mind but remain a serious danger to others due to this potential harm. The following factors may help determine whether a person poses 'serious danger':

- situational circumstances and conditions that affect the likelihood of harm occurring
- balancing the potential for harm against the nature of the proposed intervention.

Serious danger to the safety of others will normally involve the prospect that the person may be violent towards others. However, it also includes other acts likely to increase the risk of injury to others; for example, loosening the bolts on a car's wheels.²⁴

Serious danger to the safety of a person in question may arise if:

- the person's confrontational demeanour, as a result of an abnormal state of mind, makes them likely to be the victim of violence from others²⁵
- a particularly vulnerable person has a history of being sexually exploited when affected by an abnormal state of mind²⁶
- an abnormal state of mind leads to suicidal ideation.

When establishing whether a person is a serious danger to the health of others, the clinician should consider both physical and psychological health.²⁷ A person with an erotomanic fixation (where they believe someone else is in love with them, despite contrary evidence) might constitute a serious danger to the mental health of others. Evidence in *IC*²⁸ indicated that a person's obsessional attachment and stalking behaviour had caused great anxiety and fear to his victim and her family, but he had made no physical threats. The Review Tribunal held that 'there is clear and unequivocal evidence to show that [the] behaviour poses and continues to pose a serious danger to the psychological health of the victim and her family'. Another example is where a parent, who meets the definition of 'mentally disordered' and has custody of their child, may present a serious danger to the physical or mental health of that child if not subject to compulsory treatment and less restrictive options are not available.²⁹

Serious danger to the health of the person in question may occur if the person has a chronic illness such as diabetes and is unable to manage their condition due to an abnormal state of mind. The clinician should be mindful of whether a person's experiences of repeated acute bouts of mental illness may contribute to the overall deterioration of that person's condition. However, if a person does not have the capacity to make decisions related to their physical health, compulsory treatment

²⁴ *MMG*, above note 12.

²⁵ *TRK*, NZMHRT 08/114, 19 August 2008.

²⁶ *JFW*, NZMHRT 11/027, 21 April 2011.

²⁷ *RWD* [1995] NZFLR 28.

²⁸ *IC* [1996] NZFLR 562.

²⁹ *TRK*, above note 25.

under the Mental Health Act cannot be initiated for the purpose of treating physical health problems. The appropriate course of action in such circumstances is to proceed in accordance with Right 7(4) of the Code of Rights, or to seek a treatment order or an order appointing a welfare guardian under the Protection of Personal and Property Rights Act 1988.

To help balance the potential for harm against the need for compulsory treatment, clinicians may want to examine the protective factors and strengths of the person in question. That is, they may consider the situational circumstances and conditions that are going to support the person and keep them safe and self-determined. The primary source of this information must be the person being supported and, if they so choose, their family and whānau.

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

Self-care is not limited to the basic necessities of survival (activities of daily living such as food, shelter, hygiene and medication). It also includes 'the multiplicity of other needs such as achieving financial security, maintaining proper social relationships, maintaining stable accommodation and seeking out ... the assistance of others ... concerning health and lifestyle'.³⁰ Self-care has been said to embrace all of 'the higher complexities of modern living'³¹ and the 'ability to cope adequately in the community'.³²

Self-care is not simply that which is in the 'best interests' of a person, if their best interests involve behaving in some way that makes them a nuisance to others.³³ Nor does it include providing for 'the capacity to find happiness in life and fulfil potential';³⁴ these are considered to be private and individual matters independent of any mental disorder.

Self-care can also be seen as those essential functions that can be 'reasonably readily provided or addressed by others'.³⁵ The degree of outside care available to a person is a relevant factor in the mental disorder test. If the support of family, whānau or friends is present to adequately fill the functional gap created by diminished capacity, or to lessen the risks posed to self or others so that those risks are no longer 'serious', a person who is otherwise mentally disordered may be released from compulsory care.³⁶

The test of diminished capacity is neither wholly subjective nor wholly objective. A subjective test of diminished capacity may unfairly target people of a specific demographic. Although a mental illness may seriously diminish a person's capacity for self-care, the person may still cope adequately in the community. An objective test, on the other hand, may target people with a below-average capacity independent of any abnormal state of mind, such as those with an intellectual or physical disability, or who

³⁰ NZMHRT 324/95, 14 June 1995.

³¹ *AVHM*, NZMHRT 08/110, 25 August 2008.

³² NZMHRT 324/95, above note 30.

³³ *SFC*, NZMHRT 02/032, 4 November 2002.

³⁴ *AVHM*, above note 31.

³⁵ *AVHM*, above note 31.

³⁶ *TRT*, NZMHRT 09/078, 14 August 2009.

are frail due to age. In *Re C*,³⁷ the court described a mixed objective–subjective test of ‘what an ordinary citizen would find acceptable as a minimum standard of effective self-care for a person of the patient’s circumstances and background’.

Capacity for self-care is ‘unique to the individual having regard to both intrinsic and extrinsic considerations, that is to say, the qualities and characteristics of the individual, together with the features of their environment’.³⁸ This approach recognises a person’s unique skills and talents. A certain minimum capacity has been generally considered sufficient in all but the most exceptional cases, as there is a ‘broad commonality’ between the minimum capacities of most members of the community.³⁹

It is appropriate to primarily enquire as to whether a person meets an objective base-level of capacity for self-care. However, diminished capacity has sometimes been established when a person has feasible goals requiring a high level of functioning, such as running a business,⁴⁰ working as a doctor⁴¹ or attending university.⁴²

2.2 ‘Fit to be released from compulsory status’

Section 2 of the Act defines ‘fit to be released from compulsory status’ to mean ‘no longer mentally disordered and fit to be released from the requirement of assessment or treatment’ under the Act.

Note that two limbs must apply for someone to be considered mentally disordered under the Act. First, the person must have an abnormal state of mind, characterised by delusion or by disorders of mood or perception or volition or cognition of such a degree that, second, the abnormal state of mind either (1) poses a serious danger to the health and safety of that person or of others or (2) seriously diminishes the capacity of that person to take care of themselves. While these limbs may be of a continuous or intermittent nature, clinicians may also wish to consider someone’s ability to live well within their community and capacity for self-determination.

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

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

... the mental disorder definition requires a causative link between abnormality of mind and the second limb ... When it is not necessary to maintain a compulsory

³⁷ *Re C*, NZMRT 132/99, 28 August 2000.

³⁸ *Y*, NZMHRT 11/139, 18 January 2012.

³⁹ *AVHM*, above note 31.

⁴⁰ *TJF*, NZMHRT 07/037, 27 April 2007.

⁴¹ *AEAA*, NZMHRT 08/012, 7 July 2008.

⁴² *AVHM*, above note 31.

treatment order, due to good adherence to medication, for example, the severity criteria in the second limb of the mental disorder definition may no longer be met, even if the person's abnormal state of mind is still present under the first limb. In this way, the person will, therefore, be fit to be released from compulsory status because they no longer meet the definition of mental disorder (ie., there is no longer a causative link between abnormality and risk).⁴³

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

It is important to consider information or evidence about what has contributed to a person's recovery, management of their mental disorder, and ability to self-care. A patient or proposed patient can be released from compulsory status where positive aspects of their life are identified as contributing to their recovery such that they no longer meet the definition of 'mental disorder'; for example, stable employment, present support systems such as family and whānau, positive intimate relationships, accommodation and ceasing use of substances.

2.3 'Person in charge'

The Act defines the person in charge of a hospital or a service as the chief executive officer. Section 113 grants the person in charge of the hospital with the authority to admit a patient or proposed patient to a hospital and detain them there.

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

2.4 'Principal caregiver'

The Act defines the 'principal caregiver' as 'the friend of the patient or the member of the patient's family group or whānau who is most evidently and directly concerned with the oversight of the patient's care and welfare' (section 2). The meaning of principal caregiver differs from next of kin (a person's closest living relative) and family or whānau (a person's closest support network, not necessarily blood-tied). A principal

⁴³ NZMHRT 17/059, above note 11.

caregiver assumes greater responsibility for the care and welfare of the patient or proposed patient and may be the first person a service or clinician contacts.

Clinicians must contact the principal caregiver where decisions are needing to be made about a person's assessment or treatment, where practicable – that is, in relation to family and whānau consultations under section 7A (see Chapter 4.4). Note that it is possible to nominate more than one principal caregiver.⁴⁴ With consent from the patient or proposed patient, a person who wishes to become the principal caregiver may need to speak with a duly authorised officer (DAO), district inspector, DAMHS administrator or clinician about how the service formalises this status.

If the patient does not give the name of the principal caregiver, or does not authorise contacting the principal caregiver or even forbids it, this does not affect the statutory duty to contact family or whānau (section 7A) to obtain collateral information to inform the assessment process under the Act. Moreover, none of these matters affects the statutory duty to send the principal caregiver a copy of the certificate of preliminary assessment (section 10(4)(a)(iv)), further assessment (section 12(5)(d)) and final assessment (section 14A(2)(c)), and a copy of a certificate of clinical review that states that the patient is (or is not) fit to be released from compulsory status (section 76(7)(b)(iii)).

The Privacy Act 2020 does not affect the clear statutory duty of notification in these circumstances;⁴⁵ nor does the Health Information Privacy Code 2020 or the Code of Rights.

If the patient is competent to make a decision about who is the principal caregiver, their advice as to who the principal caregiver is should be accepted. The patient may also have given this information in an advance directive. Even if a patient is not competent to choose a principal caregiver, their preferences should be given significant weight.

For many patients, there is no dispute as to who the 'principal caregiver' is. If there is doubt or disagreement, the viewpoints that need to be considered are those of:

- the patient
- spouse or partners
- the family or whānau
- friends of the patient
- an enduring power of attorney
- health professionals in the service
- other parties concerned with the care of the patient (for example, prison staff if the person is detained in custody).

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

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

⁴⁴ *HM* [1999] NZFLR 858.

⁴⁵ *EW*, 24/1/96, Judge McElrea, DC Auckland.

The responsible clinician or appropriate DAO involved will advise the DAMHS. In cases of dispute, the DAMHS should consult with other knowledgeable parties – for example, a social worker. In cases of dispute with patients who identify as Māori, the DAMHS should also consult with Māori health workers and cultural support staff.

Section 7A of the Act also creates an obligation to consult with the family or whānau of the patient or proposed patient (see 4.6: ‘Who to consult’ below).

2.5 ‘Health practitioner’

‘Health practitioner’ under the Act has the same meaning as in section 5 of the Health Practitioners Competence Assurance Act 2003: that is, a person who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession.

‘Mental health practitioner’ as defined in section 2 of the Act, is

- a medical practitioner
- a nurse practitioner or
- a registered nurse practising in mental health (which is also defined in section 2 of the Act).

For the purposes of section 7 of the Act (‘Obligation to assign patient to responsible clinician’), the DAMHS is responsible for ensuring that each patient at all times has an assigned responsible clinician. The responsible clinician can be a psychiatrist approved by the DAMHS (section 7(a)) or some other registered health professional who, in the opinion of the DAMHS, has undergone training in, and is competent in, the assessment, treatment and care of people with mental disorders (section 7(b)).

The DAMHS has the authority to ensure that they can match patient needs to the responsible clinician’s skills and experience at each particular phase of the assessment and treatment process (with respect to section 8B(6) and 9(3) of the Act). It may, therefore, be appropriate for some clinicians to act as responsible clinicians with a patient at one or more specific stages of assessment and treatment. For example, clinical psychologists are trained in the assessment, diagnosis and treatment of mental disorders. They bring skills and experience that might better fit the patient’s needs. Broadening the application of the skills and experience that other health practitioners offer can reflect patients’ right to treatment that is appropriate to their condition (section 66 of the Act), while potentially increasing the resource of those who can act as responsible clinicians.

2.6 ‘Registered nurse practising in mental health’

The Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill came into effect on 31 January 2018. Further amendments occurred in August 2020. One of the key laws changed was the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act) which aimed to:

- allow for health practitioners with the required competencies and knowledge to perform more statutory functions
- make it easier for the public to access statutory health services.
- allow the health workforce to use their knowledge and skills; and
- facilitate innovative services and efficient practices.

One key change was to allow Nurse Practitioners and Registered Nurses, practicing in mental health, to be able to issue a certificate (section 8B) to accompany an application for assessment.

The Act defines a ‘registered nurse practising in mental health’ as:

... a health practitioner who is, or is deemed to be, registered with the Nursing Council of New Zealand by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice includes the assessment of the presence of mental disorder as defined under this Act; and who holds a current practising certificate.

The change was not intended for nurses to replace medical practitioners, but rather to provide an alternative when unreasonable delay would occur if a medical practitioner were unavailable. This will more likely be required in rural and remote areas than urban areas.

As health practitioners, nurses are responsible for practising both within their scope of practice as defined by the Nursing Council of New Zealand and within their level of competence. A ‘registered nurse practising in mental health’ for these purposes could be a registered nurse who works in a mental health context, or who has a significant mental health component to their work, with postgraduate papers specific to mental health, and practice experience.

The DAMHS, in collaboration with their Director of Mental Health Nursing, or equivalent senior nurse role, should conduct a process for identifying which registered nurses within the DAMHS’ locality are suitably competent for this role. The process for application should be communicated to the relevant services and agencies within their area. This process can include nurses in other areas of practice, for example, Ara Poutama, primary/Non-Government Organisations/iwi providers and other settings or agencies.

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

provide specific training to help registered nurses working in mental health to complete a section 8B certificate.

For more information, see:

- Guidelines for the Role and Function of Statutory Officers Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 on the Ministry of Health website under, the Mental Health Act Guidelines and Resources section
- Te Ao Māramatanga New Zealand College of Mental Health Nurses. 2018. *Practice note: Nursing practice and section 8B – Mental Health (Compulsory Assessment and Treatment) Act 1992*. Auckland: Te Ao Māramatanga New Zealand College of Mental Health Nurses.

3 Section 4:

Exclusion criteria

Section 4 of the Mental Health Act prohibits compulsory assessment and treatment by reason only of a person's political, religious or cultural beliefs, their sexual preference, criminal or delinquent behaviour, substance abuse [use] or intellectual disability. However, section 4 does not prohibit assessment and treatment of patients who have a mental disorder but might otherwise fit within one of the section 4 categories. In *Re H*,⁴⁶ Judge Inglis summarised the position.

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

The exclusion factors in section 4 indicate some of the limits of imposing compulsory treatment. People cannot be detained in a psychiatric hospital for their political, religious and cultural beliefs, or sexual preference (section 4(a) and (b)).

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

Section 4(d) of the Act, which excludes 'substance abuse' as a sole reason for compulsory assessment and treatment, is discussed under 3.1: 'Substance use'. Section 4(e) of the Act excludes the application of the Act on the grounds of intellectual disability alone, and is discussed under 3.2: 'Intellectual disability'.

⁴⁶ *H [Mental Health]* (1993) 10 FRNZ 422.

Note: The Act uses the term ‘substance abuse’ to mean individuals that have problematic use of substances (drugs or alcohol). However, because the term ‘substance abuse’ does not align with modern practice, these guidelines use ‘substance use’ unless directly quoting legislation.

Substance use and intellectual disability may contribute to a person’s abnormal state of mind, as long as substance use or intellectual disability is not the sole cause of a person’s abnormal state of mind. However, an assessing clinician or judge may consider the risks that arise as a result of any aspect of that person’s abnormal state of mind, including a person’s substance use or intellectual disability, when determining whether a person is mentally disordered (see 2.1.3: ‘Characterised by delusions, or by disorders of mood or perception or volition or cognition’ above).

3.1 Substance use

Section 4(d) of the Act specifically excludes substance use (drugs or alcohol) as a sole basis for applying procedures for compulsory assessment and treatment under the Act. But the presence of substance use does not rule out the use of the Act if a person otherwise meets the criteria for ‘mental disorder’.

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

- When an intoxicated individual displays suicidal behaviour, or threatens suicide or self-harm, it may be appropriate to use the Mental Health Act. It may be reasonable to form the belief that someone who is threatening suicide or acting in a suicidal manner may be mentally disordered, no matter how intoxicated they are.
- The acute effects of intoxication may present as a mental disorder; for example, the effects of hallucinogenic drugs may mimic psychotic symptoms or stimulant drugs may exacerbate hyperactivity. People in such a state will often meet the lower threshold for assessment and treatment under Part 1 of the Act; that is, there will be reasonable grounds to believe that they are mentally disordered until the cause of their symptoms becomes apparent (see 5.1: ‘Threshold for applying for compulsory assessment’ below).
- Mental disorder may arise as the consequence of long-term substance use; for example, the cognitive impairment of a Korsakoff’s psychosis. If a person has a mental disorder, no matter what its underlying cause, the Mental Health Act may apply. Use of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (the Substance Addiction Act) may be more appropriate in these circumstances; however, the Mental Health Act should be prioritised over the Substance Addiction Act if the person meets the definition of ‘mental disorder’ under the Mental Health Act.
- Individuals who have a ‘dual-diagnosis’ or ‘co-morbidity’ of a mental disorder and a substance use disorder will require additional support and consideration.

The terms of a community treatment order or leave from an inpatient order under the Mental Health Act can specify whether the package of care should include abstinence from substances. Substance use and substance use disorders are often described as a chronically relapsing condition in which a person continues to take a substance (or multiple substances) despite experiencing problems as a result. Recovery from substance use is often characterised by a journey of relapse and lapse. Where individuals are unable to abstain, or can abstain only for periods of time, a harm minimisation approach must be taken that supports the individual to consider ways that their substance use impacts their mental health and day-to-day functioning as much as possible.

The Substance Addiction Act allows for compulsory treatment of people who have a severe substance addiction if their capacity to make decisions about treatment for that addiction is severely impaired. Treatment must be considered to be necessary and appropriate treatment must be available. The intention is to protect the person from serious harm, stabilise their health, protect and enhance their mana and dignity, and restore their capacity to make informed decisions about further treatment and substance use.

The Substance Addiction Act defines 'severe substance addiction' as an addiction with such severity that it poses a serious danger to the health or safety of the person and seriously diminishes the person's ability to care for himself or herself.

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

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

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

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

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

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

Compulsory treatment should not be applied to any person based only on the reason of substance use (including addiction). If a patient or proposed patient under the Mental Health Act presents with substance use issues, mental health services should engage with local addiction services to support the person to address their substance use.

3.2 Intellectual disability

Section 4(e) of the Mental Health Act specifically excludes intellectual disability as a sole basis for applying procedures for compulsory assessment and treatment under the Act. But the presence of intellectual disability does not rule out the use of the Mental Health Act if a person otherwise meets the criteria for 'mental disorder'.

Examples of situations where people may experience both intellectual disability and mental disorder include:

- intellectually disabled people who present a serious danger to the safety of others due to a co-morbid psychosis, and who may be treated under either the Mental Health Act or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- people with intellectual disability who develop dementia at an earlier age than the general population;⁴⁷ this group includes but is not limited to those with Down syndrome
- people with intellectual disability who experience a greater prevalence of a range of mental disorders compared with the general population.

A common misconception is that people may be detained under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 purely on the basis of the risk of harm they pose to themselves or others. However, for ethical, legal and clinical reasons, this cannot occur. The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 provides a legislative basis for the compulsory care of intellectually disabled people who have been charged with an imprisonable offence (and found unfit to stand trial) or have been convicted of an imprisonable offence.

⁴⁷ In early stages of determining what is causing serious danger or inability to care for themselves, clinicians may consider that people have a disorder of cognition. However, once dementia is established, the ongoing support and treatment options would normally be managed under the Protection of Personal and Property Rights Act 1988.

When a person with an intellectual disability is also experiencing and being treated for a mental disorder, it is important for mental health clinicians to involve clinicians who specialise in the care of intellectually disabled people.

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

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

Sections 5 and 6 of the Mental Health Act require powers to be exercised with respect for a person's culture, language and beliefs. The use of the word 'person' in sections 5 and 6 indicates that the right for respect of cultural identity and language starts at the initial assessment phase and continues throughout the treatment process.

To meet the requirements of sections 5 and 6 of the Mental Health Act, staff need to know how to access the services of an interpreter and appropriate cultural advisors, often at short notice. Meeting the responsibilities under sections 5 and 6 of the Act is considered to be part of providing the overall proper care of a patient or proposed patient, and should not be unnecessarily hindered.

4.1 Cultural identity

Section 5 requires the powers of the Mental Health Act 'to be exercised with proper respect for cultural identity and personal beliefs', including under subsection 5(2):

- (a) with proper recognition of the importance and significance to the person of the person's ties with [their] family, whānau, hapū, iwi, and family group, and
- (b) with proper recognition of the contribution those ties make to the person's wellbeing, and
- (c) with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.

The basic patient right (under section 65 of the Mental Health Act) to be dealt with in a culturally appropriate manner becomes enforceable through the complaints procedures set out in section 75. This requirement is reinforced by:

- Right 1(3) of the Code of Rights, which states that 'every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values and beliefs of Māori'
- section 15 of the NZBORA, which states that every person has the right to manifest that person's religion or belief in worship, observance, practice or teaching, either individually or in community with others, and either in public or in private.

Strong evidence supports the need for giving proper respect for cultural identity and personal beliefs of people who enter mental health services. Māori are significantly over-represented among the populations treated under the Act.⁴⁸ It is likely that several factors contribute to this, including significant disparities between Māori and non-Māori in rates of serious mental illness, co-existing conditions and complex and late presentations.⁴⁹

Section 66 of the Mental Health Act affirms a patient's right to receive medical care and other health care that is appropriate to their condition. Substantive treatment that takes account of a patient's cultural identity and personal beliefs is an inherent component of a patient's right to medical treatment and health care appropriate to their condition.

4.1.1 Culturally safe care

It is important that services demonstrate culturally safe care, which they can achieve through ongoing training on cultural safety. Culturally safe care 'focuses on the patient experience to define and improve the quality of care. It involves [health care professionals] reflecting on their own views and biases and how these could affect their decision-making and health outcomes for the patient'.⁵⁰

Culturally safe care is demonstrated when health care staff:

- show respect for a patient's beliefs and values
- are aware that they may disadvantage the patient by imposing their own beliefs and values. Showing respect can help direct a patient towards better health.

Services must work with the patient or proposed patient and their family, whānau and principal caregiver to provide care that is responsive to the needs of people of any culture. Services should monitor and record whether or not a cultural assessment has been made and why. Moreover, if a cultural assessment has not taken place, arrangements should be made to do so. We encourage services to engage people in a cultural assessment process or refer people for cultural assessment by, for example, kaupapa Māori or Pacific health services or other culturally relevant services.

Māori and Pacific peoples are significantly over-represented under the Mental Health Act. For this reason, services are expected to be capable of delivering care that is responsive to and respectful of the cultures of these populations.

Services must have relevant knowledge and understanding about cultural and personal beliefs to ensure that the process of providing care and treatment is appropriate, and to better understand how the person and their family or whānau may perceive or frame any diagnosis.

⁴⁸ Ministry of Health, 2019, above note 6.

⁴⁹ Elder H, Tapsell R. 2013. Chapter 14. In: J Dawson, K Gledhill (eds) *New Zealand's Mental Health Act in Practice*. Wellington: Victoria University Press.

⁵⁰ Medical Council of New Zealand. 2019. Statement on cultural safety. Wellington: Medical Council of New Zealand. URL: <https://www.mcnz.org.nz/assets/standards/b71d139dca/Statement-on-cultural-safety.pdf> (accessed 28 July 2020).

Te Whare Tapa Whā

One model for understanding hauora Māori is Mason Durie's concept of 'Te Whare Tapa Whā', the four cornerstones of Māori health.⁵¹ The model uses the concept of a whare (house) to describe four key dimensions of Māori wellbeing. All four walls are needed and must be in balance for the house to be strong. If one of the four dimensions is missing or in some way damaged, a person or a collective may become 'unbalanced' and subsequently unwell.

The dimensions described in Te Whare Tapa Whā are:

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

The Meihana model

Developed in 2007, the Meihana model is available for health practitioners to consider how they deliver assessments and determine what treatment options for Māori patients.⁵² It extends the application of Te Whare Tapa Whā by taking into account:

- the waka hourua (a double-hulled canoe representing the patient and their whānau)
- aku (beams connecting the two canoes: wairua, tinana, hinengaro, taiao and iwi katoa)
- ngā hau e whā (the four winds: colonisation, racism, migration and marginalisation)
- ngā roma moana (ocean currents: ahua, tikanga, whānau and whenua)
- whakaterere (navigating).

The Meihana model considers the unique circumstances that a Māori patient and their whānau may face when looking into their health, by navigating the best possible model of care that envelops their current, historical and generational experiences across broad aspects of health.

Mana-enhancing practice

The Substance Addiction Act explicitly requires services to enhance an individual's mana. To support practitioners delivering services under the Substance Addiction Act, Te Rau Ora (originally Te Rau Matatini) has developed a guide for mana-enhancing and mana-protecting practice, *Manaaki*.⁵³ This guide was developed for service delivery under the Substance Addiction Act, but it includes useful information and guidance

⁵¹ Ministry of Health. 2017. Māori health models – Te Whare Tapa Whā. URL: <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha> (accessed 24 July 2020).

⁵² Pitama SG, Robertson P, Cram F, et al. 2007. Meihana model: a clinical assessment framework. *New Zealand Journal of Psychology* 36(3): 107–99.

⁵³ Huriwai T, Baker M. 2016. *Manaaki: Mana enhancing and Mana protecting practice*. Wellington: Te Rau Matatini. URL: <https://terauora.com/wp-content/uploads/2019/05/Manaaki-Mana-Enhancing-and-Mana-Protecting.pdf> (accessed 24 July 2020).

related to the concepts of mana and mana-enhancing practice that can be applied to services delivered under the Mental Health Act.⁵⁴

Although the Mental Health Act does not have an explicit requirement for services to enhance a person's mana, the obligation to respect cultural identity and personal beliefs under section 5, the right to this respect under section 65, and the application of the principles of Te Tiriti o Waitangi necessitates services to deliver care in a way that prioritises and ultimately upholds the mana of whānau and the patient's right to tino rangatiratanga.⁵⁵

Pacific models of care

In feedback to the Government Inquiry into Mental Health and Addiction, Pacific mental health and addiction providers stated that current service delivery under the Mental Health Act is not considering and is not culturally responsive to specific Pacific world views.⁵⁶

A key model for engaging with Pacific peoples is the Fonofale model of health.⁵⁷ Under this the model, which has similarities to Te Whare Tapa Whā and the Meihana model, the roof of the fale represents cultural values and beliefs that are the shelter for life. The foundation of the fale represents family, which is the foundation for all Pacific Island cultures. The four pou (posts) go from the foundation to support the roof. The four pou each represent a different dimension that connects family and culture together:

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

The fale is enveloped by time, environment and context dimensions, deepening the significance and impact of a Pacific person's historical and present surroundings. For example, consider the difficulties Pacific peoples (or any migrant population) face growing up and living somewhere outside of their homelands and how this might impact the connection they have to their culture and belief system.

Another key Pacific health model that can be considered and applied in the mental health context is the Popao model of recovery.⁵⁸ This model uses the analogy of the

⁵⁴ Huriwai and Baker, 2016, above note 53.

⁵⁵ For more information, see: Māori Advisory Group. 2020. Mental health and addiction quality improvement programme: Tools and resources provided by the group. Wellington: Health Quality & Safety Commission.

⁵⁶ Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction.

⁵⁷ Pulotu-Endemann FK. 2001. Fonofale model of health. URL: <https://d3n8a8pro7vhmx.cloudfront.net/actionpoint/pages/437/attachments/original/1534408956/Fonofalemodel explanation.pdf?1534408956> (accessed 24 July 2020).

⁵⁸ Fotu M, Tafa T. 2009. The Popao model: a Pacific recovery and strength concept in mental health. *Pacific Health Dialog* 15(1): 164–70. URL: <https://www.tepou.co.nz/uploads/files/resource-assets/the-popao-model-a-pacific-recovery-and-strength-concept-in-mental-health.pdf> (accessed 24 July 2020).

popao, an outrigger canoe, and emphasises the concept that the mental health treatment process is a journey towards recovery and strength within a Pacific paradigm.

For more information about the overall health of Pacific peoples in Aotearoa New Zealand, see: Ryan D, Grey C, Mischewski B. 2019. *Tofa Saili: A review of evidence about health equity for Pacific peoples in New Zealand*. Wellington: Pacific Perspectives Ltd.

4.1.2 Recognition of family and whānau

Section 5(2)(a) explicitly requires family and whānau relationships to be recognised if they are beneficial to a person's wellbeing. Family and whānau should be encouraged to provide information about the person's history, as well as feedback on any changes they notice when the person is on leave or in the company of family or whānau members. It is important to involve family or whānau throughout the continuum of care.

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

The Privacy Act 2020 and the Health Information Privacy Code 2020 do not prevent family or whānau members from providing information and do not prevent services from providing family or whānau members and other caregivers with information about the person,⁵⁹ in circumstances where, for example:

- disclosure was one of the purposes for which the information was collected⁶⁰
- there is a serious threat of self-harm by the person⁶¹
- the person is being discharged into the care of family or whānau.

Clinicians should help a person's family or whānau to understand aspects of the person's illness if the family or whānau is expected to be a part of their support group. For example, clinicians should encourage family or whānau to attend appointments with the care team to learn how best to support their loved one. Chapter 5 reiterates the obligation under section 7A to consult family or whānau, and suggests ways of carrying out consultation.

⁵⁹ See Ministry of Health. 1996. *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services (The Mason Report)*. Wellington: Ministry of Health. Chapter 4.

⁶⁰ See section 6, Information Privacy Principle 11(a), Privacy Act 2020.

⁶¹ See section 6, Information Privacy Principle 11(f)(ii), Privacy Act 2020.

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

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

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed a position statement to provide guidance on how consideration of religion and/or spirituality can improve outcomes for people living with mental illness.⁶² The guidance is relevant to clinicians working with patients and proposed patients and their families and whānau under the Mental Health Act.

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

Sexual orientation, gender identity and expression, and sexual characteristics

Although section 5 of the Act does not explicitly refer to a person's sexual orientation, gender identity and expression, or sex characteristics (SOGIESC), the Ministry of Health is committed to improving health care for all people with diverse SOGIESC.⁶³ Health and disability services and staff who work within the sector should actively work towards meeting the needs of all Aotearoa New Zealanders, with acknowledgement, inclusiveness and respect. This includes referring to a person by their preferred name and pronoun and asking open-ended questions to avoid assuming the 'categories' a person may identify with.⁶⁴

There are many different terms that a person with diverse SOGIESC might identify with. Some people may not conform to or identify with binary gender norms and may identify as non-binary. Each person's gender expression (how they present to the world) is unique. A person's gender may change over time and some people may not identify with any gender. 'Transgender' is a commonly used term by people whose gender varies from their recorded sex at birth. Transgender people will have their own

⁶² RANZCP. 2018. The relevance of religion and spirituality to psychiatric practice. Position statement 96. URL: <https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/the-relevance-of-religion-and-spirituality-to-psyc> (accessed 24 July 2020).

⁶³ SOGIESC is an umbrella term, similar to LGBTIQ+, rainbow and MVPFAFF that describes the many people who identify within it.

⁶⁴ Fraser G. 2019. *Supporting Aotearoa's Rainbow People: A practical guide for mental health professionals*. Wellington: Youth Wellbeing Study and Rainbow YOUTH.

individual transition goals, which may or may not include different aspects of social or mental health, and medical or surgical care.

Diverse SOGIESC also has different indigenous and cross-cultural understandings. For example, takatāpui embraces all Māori with diverse gender identities, sexualities and sex characteristics including whakawāhine, tangata ira tāne, lesbian, gay, bisexual, trans, intersex and queer. It emphasises Māori cultural and spiritual identity as equal to gender identity, sexuality or having diverse sex characteristics.⁶⁵

In addition, Pacific Island countries each have their own history and understanding of sexuality, sex and gender diversity that contrasts with Western concepts. Pacific peoples may not use the umbrella terms 'LGBTQI+' and 'rainbow' because these have a more medical meaning or fit groups within groups, which goes against the very fabric of traditional Pacific terminology.⁶⁶ An abbreviation to help understand the different perspectives of Pacific Island countries is 'MVPFAFF', which represents: mähū in Tahiti and Hawai'i; vaka sa lewa lewa in Fiji; palopa in Papua New Guinea; fa'afafine in Samoa and American Samoa; akava'ine in the Cook Islands; fakaleiti or leiti in the Kingdom of Tonga; and fakafefine in Niue.

Note that people have varying experiences of sexuality and gender, so it is important to acknowledge whether or not these experiences impact on their mental health.⁶⁷

A person's sexuality and gender experience may not be relevant to the reasons a person has engaged with mental health services. On the other hand, some people experience distress as a result of the discrepancy between their gender identity and their recorded sex at birth (often referred to as gender dysphoria)⁶⁸ or their sexual orientation, or as a result of the stigma attached to this experience. If it is relevant, acknowledging this experience can enrich a person's support in mental health services. When engaging with a person with diverse SOGIESC in mental health and addiction services, a clinician or service may also need to consider intersectionality and minority stress.

Intersectionality⁶⁹ is a concept that acknowledges that people who experience one form of marginalisation may also experience other forms of marginalisation, based on their ethnicity, socioeconomic status and SOGIESC. For example, trans Pacific youth may experience not fitting into rainbow non-governmental organisations or with Pacific health services, and find little support for these overlaps.⁷⁰ Such forms of marginalisation may contribute to the development of mental distress and, when a

⁶⁵ Kerekere E. 2017. *Part of the Whānau: The emergence of Takatāpui identity – He Whāriki Takatāpui*. Wellington: Tiwhanawhana Trust.

⁶⁶ Brown-Acton P. 2011. *Keynote Presentation: Movement building for change*. URL: http://www.pridenz.com/apog_phylesha_brown_acton_keynote.html (accessed 24 July 2020).

⁶⁷ Mental Health First Aid Australia. 2016. *Considerations when providing mental health first aid to an LGBTIQ+ person*. Melbourne: Mental Health First Aid Australia.

⁶⁸ Ministry of Health. 2017. *Transgender New Zealanders*. URL: <https://www.health.govt.nz/your-health/healthy-living/transgender-new-zealanders> (accessed 24 July 2020).

⁶⁹ Crenshaw K. 1989. Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum* (1): 139–67. URL: <https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf> (accessed 24 July 2020).

⁷⁰ Government Inquiry into Mental Health and Addiction. *Mental Health Inquiry Pacific Report*. URL: <https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/Pacific-report.pdf> (accessed May 2020).

person experiences a combination of them, they have a compounding negative impact.⁷¹

Minority stress⁷² is how the external world affects the internal world. Social stigma and discrimination create a hostile and stressful environment for sex, sexuality and gender diverse people.

For further information about what else to consider when providing care and support to a person of the rainbow community, see: Fraser G. 2019. *Supporting Aotearoa's Rainbow People: A practical guide for mental health professionals*. Wellington: Youth Wellbeing Study and Rainbow YOUTH.

Additionally, in 2020 the Human Rights Commission released *Prism: Human rights issues relating to sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) in Aotearoa New Zealand – a report with recommendations*. This report explores human rights issues related to people with diverse SOGIESC, exploring six human rights as identified by the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights.

4.2 Section 6: Use of interpreters

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

As an example, many people within the Deaf community use sign language as their first language and their main source of communication. People in this community see themselves as a distinct culture and experience unique pressures that affect their mental health.⁷³ Mental health services should be responsive to people, patients and proposed patients who are Deaf by ensuring that a competent interpreter is available to them, and by ensuring that staff members are aware that a Deaf individual's culture surrounding their deafness has specific relevance and meaning.

A registered New Zealand Sign Language interpreter is considered a competent interpreter for the Deaf. For an updated list of registered New Zealand Sign Language interpreters, contact your regional Deaf Association office or the Sign Language Interpreters Association of New Zealand.

⁷¹ Chiang SY, Fleming T, Lucassen M, et al. 2017. Mental health status of double minority adolescents: findings from national cross-sectional health surveys. *Journal of Immigrant and Minority Health* 19(3): 499–510.

⁷² Dentato MP. 2012. The minority stress perspective. *Psychology and AIDS Exchange Newsletter* April. URL: <https://www.apa.org/pi/aids/resources/exchange/2012/04/minority-stress> (accessed 24 July 2020).

⁷³ Ministry of Health. 1997. *Moving Forward: The national mental health plan for more and better services*. Wellington: Ministry of Health, pp 42–43.

Right 5(1) of the Code of Rights reinforces this requirement by stating that ‘Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter’.

In practice, section 6(2) of the Act means that the court, tribunal or person exercising any power under the Act should seek out the wishes of the person. They should not assume that a person is happy to communicate in English simply because they are able to do so. Section 6(2) of the Act also recognises that people have the right to choose to communicate in another language. Under section 6(3), the court, tribunal or person exercising any power under the Act must ensure, as far as is reasonably practicable, that the interpreter provided is competent.

The service must provide means of accessing appropriately trained interpreters for the patient or proposed patient, where practicable. However, by separating the requirement to seek an interpreter in section 6(2) from the requirement for a competent interpreter in section 6(3), the Act recognises that sometimes a competent interpreter, whether by accreditation as an interpreter, membership of an industry body (such as the New Zealand Society of Translators and Interpreters), employment as an interpreter, or otherwise, will not be available.

In some situations, it may not be reasonably practicable to engage a competent interpreter. However, an ‘amateur’ interpreter who is fluent in the person’s language and willing to act as an interpreter may offer an alternative that can help the person until the services of a competent interpreter can be engaged. We recommend only involving a family or whānau member as interpreter as the last choice, because their involvement may increase risk of bias and/or distress for both the individual and their family or whānau member.

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

The district inspector has a key role in advising patients of their rights both at the start of the second assessment period and when the responsible clinician requests a compulsory treatment order. For this reason, every effort should be made to ensure that a competent interpreter is available when required to facilitate an interview between the patient and district inspector.

4.3 Section 6A Guidance on the use of Audio-Visual Link Technology

4.3.1 Use of audio-visual link (AVL) Technology for patient assessments

Section 6A of the Act enables (AVL) technology to be used for patient assessments and examinations when the physical presence of a patient is not practicable and that it is appropriate in the circumstances.

Under section 6A the use of AVL is permitted if a clinician, mental health practitioner, or psychiatrist (a **practitioner**) exercises a power under the Act that requires access to a person. Or if a Judge, any person directed by a Judge, or a member of a Review Tribunal is required to examine a person under the Act.

The use of AVL in relation to the exercise of a power in respect of a person under the Act, means facilities that enable both audio and visual communication with the person.

To avoid doubt, an examination may not be carried out under this section (6A) by audio link only.

Using AVL in mental health consultations is supported by the Royal Australian and New Zealand College of Psychiatrists (RANZCP), which notes that “Telepsychiatry can greatly improve access to psychiatric services for people in rural and remote areas, and in other **situations where face-to-face consultations are impracticable.**” Resources to help implement telepsychiatry are provided on the College website at <https://www.ranzcp.org/practice-education/telehealth-in-psychiatry>.

Appropriate equipment will need to be available to ensure that assessments are conducted effectively.

4.3.2 Determining whether the use of AVL technology is appropriate

Face-to-face assessments are the preferred method of examination and the use of AVL should not become the default method of assessment and examinations under the Mental Health Act. AVL technology should not be used to ease pressure on services when staff resources are limited.

Mental health care providers should consider a range of factors when determining whether it is practicable for the patient to attend in person. They include:

- the preference and best interests of the patient or proposed patient

- the least restrictive manner of providing assessment and treatment
- whether the use of AVL technology would aggravate the patient or proposed patient's condition (eg, if they have beliefs about being monitored or controlled by the hidden cameras or the TV)
- whether barriers to in-person attendance would prevent timely access to assessment and treatment.
- the ability to maintain safety
- the effective facilitation of family/whānau engagement
- consideration of cultural needs especially if family/whānau unable to support or be engaged.

It is important to note that AVL should not be used for the entirety of the early assessment and examination stages of the Act. Greater priority should be given to in-person assessments for the purposes of assessment under sections 8B to 14 of the Act. More specifically, there should be at least one examination in person for the purpose of sections 8B to 10, as these relate to decisions that may result in a person being detained against their will, thus placing significant limitations on their rights and civil liberties.

4.3.3 Consent

Consent by the patient or proposed patient to conduct an assessment, examination, or review by AVL is not required, but services are encouraged to seek and document consent whenever possible.

A lack of consent does not make it unlawful to do an assessment by AVL in itself. However, it 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 inappropriate or contrary to legal requirements.

Where an individual is not cooperative in relation to the use of AVL, services are encouraged to think carefully about whether the use of AVL remains appropriate in the circumstances and consider alternatives such as an in-person assessment. Services should document the decision-making process, including recording how the interests and clinical safety of the patient were better served by an AVL assessment in the situation, and consider guidance provided by relevant professional practice standards.

4.3.4 Documentation

If an AVL is used in relation to the exercise of a power in respect of a person under the Act, the practitioner must record in writing:

- the reason that it was not practicable for the person to be physically present; and
- why the use of an AVL was appropriate in the circumstances; and
- provide the record of this to the relevant DAMHS as soon as practicable after the use of the link.

Services must have appropriate protocols in place for conducting and documenting assessments by AVL.

4.3.5 Monitoring the use of AVL technology

Monitoring the use of AVL technology is necessary to ensure that it is appropriate and does not disadvantage patients. The Ministry of Health will be monitoring the use of AVL technology in several ways:

- District Inspects will be reviewing documentation and reporting on AVL use in their monthly reports to the Director of Mental Health
- DAMHS will be required to report on the use of AVL in their quarterly reports to the Director of Mental Health.

Services must ensure that AVL arrangements respect the privacy of the individual, and requirements under the Health Information Privacy Code 2020 and Privacy Act 2020 are complied with.

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

It is mandatory for an explanation of the purpose of the assessment to take place in the presence of a support person under section 9(2)(d). An assessor must offer to organise the attendance of a support person known to the applicant, such as a family member, caregiver or friend, if such a person is available. If no such person is available, an independent person should be engaged (Justices of the Peace (JPs) are available for this purpose).

The use of AVL can be used to fulfil the requirements of section 9(2)(d) unless it is not possible. If full AVL technology is not available in the circumstance, a teleconference is permissible in this situation only.

Care must be taken to ensure that all parties can adequately participate in the interaction, and that all parties have understood the information provided.

Although practitioners are expected to apply the guidelines, there is an explicit requirement in the legislation under section 6A(2A) of the Act to do so. Note that this is similar to a provision in section 7A of the Act, which requires a practitioner to consult with the patient or proposed patient's family or whānau.

4.4 Section 7A: Consultation and ongoing obligation to work with family and whānau

Section 7A of the Mental Health Act reinforces that family and whānau are a crucial dimension in the overall wellbeing or hauora of Māori (see 4.1.1: 'Culturally safe care' above) and non-Māori. Section 7A puts an ongoing obligation on mental health practitioners (conducting an assessment under section 9) and responsible clinicians (providing assessment and treatment) to consult with and involve family and whānau in decisions made concerning assessment and treatment.⁷⁴

Section 7A states that a mental health practitioner or responsible clinician **must** consult with family or whānau during the compulsory assessment and treatment process, unless it is not in the 'best interests' of the patient or proposed patient or it is not 'reasonably practicable'. For comprehensive guidelines on consultation with family and whānau, see: RANZCP. 2000. *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes*. Wellington: Ministry of Health.

The purpose of consultation with family or whānau is to:

- strengthen the involvement of family or whānau in the compulsory assessment and treatment process
- enhance the contribution of the family or whānau to the subsequent care of the patient or proposed patient
- alleviate family or whānau concerns about information sharing and treatment options
- facilitate ongoing involvement of the family or whānau in Mental Health Act processes such as clinical reviews of treatment or court hearings.

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

- when and how to engage with a family or whānau or the patient or proposed patient
- whether consultation with family or whānau is reasonably practicable
- whether consultation with family or whānau is in the best interests of the patient or proposed patient.

⁷⁴ In practice, a DAO may have had discussions with family or whānau, and the mental health practitioner or responsible clinician could use the information the DAO learnt from the discussions. While this does not remove the responsibility for the mental health practitioner or responsible clinician to consult family or whānau, the information gained from a DAO could be used to inform part of the assessment and treatment of a patient or proposed patient.

The clinician must acknowledge the relationships that a patient or proposed patient has with their family and whānau, a principal caregiver, or another person and support network that they trust. Where consultation with family or whānau is not practicable, or not in the best interests of the patient, the clinician should ask the patient or proposed patient if there is a person or support network who knows them well and is involved with their ongoing health and care. It is possible this person or support network might meet the definition of family or whānau as discussed under '5.2: Who to consult' below.

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

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

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

Where patients or proposed patients have an impending assessment, hearing or review, a copy of the documentation may be given to their welfare guardian, principal caregiver, primary health care provider, the DAMHS, a district inspector and an official visitor. We advise also notifying the family and whānau and inviting them to attend upcoming hearings, where reasonably practicable and in the best interests of the patient (or proposed patient), and providing this information with enough time in advance so that they can get time off work to attend.

Consultation may require the mental health practitioner or responsible clinician to disclose personal and health information about a patient or proposed patient to their family or whānau. They need to do so particularly when developing a treatment, discharge or recovery plan in which family or whānau will be involved in maintaining a person's wellness in the community.

The disclosure of information for the purposes of consultation under section 7A **is not** a breach of the Privacy Act 2020 or Health Information Privacy Code 2020.⁷⁵ However, it is desirable to discuss the consultation process with the patient or proposed patient in advance, so they understand the purpose of consultation and the extent to which information will be shared.

⁷⁵ See sections 24 and 38 of the Privacy Act 2020.

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

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

The names and contact details of family or whānau members consulted should be recorded on the initial assessment record form, and the nature of the consultation (and the relationship) recorded in the clinical file of the patient or proposed patient.

The mental health practitioner or responsible clinician should obtain consent from the patient or proposed patient to consult family or whānau. However, consent is not always required, such as when a patient is acutely unwell or lacks capacity to consent. The requirement to consult does not mean a patient or proposed patient gives up their right to confidential care and treatment. The rights of patients and proposed patients, and the protection of those rights, continue to be paramount and a major philosophical tenet of the Act.

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

Where family or whānau have been consulted to develop a treatment, discharge or recovery plan in which they will be involved in a person's continuing care, a clinician may share a copy of the plan with those family or whānau members most closely involved in delivering that care. This is a permitted disclosure of information for the purpose for which it was collected.⁷⁶

The responsible clinician should also make family, whānau and/or the principal caregiver aware that they may contact a district inspector (and inform them how to access a district inspector) about any legal processes of the Mental Health Act.

⁷⁶ Rule 11(c), Health Information Privacy Code 2020.

Additionally, family and whānau who must travel long distances to visit their loved ones may be eligible for the National Travel Assistance Scheme to cover costs of transport and accommodation. For more information about the National Travel Assistance Scheme, go to the Ministry's website (www.health.govt.nz) and search for 'NTA' or 'National Travel Assistance'.

4.5 Who must consult

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

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

4.6 Who to consult

4.6.1 Defining 'family and whānau'

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

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

'Family and whānau' means a set of relationships a patient or proposed patient recognises as their closest connections, whether those connections are with a collective or an individual. The relationships are not limited to those based on blood ties and may include any of the following:

- the spouse or partner of the patient or proposed patient
- relatives of the patient or proposed patient
- a mixture of relatives, friends and others in a support network
- only non-relatives of the patient or proposed patient.⁷⁷

Where a patient's or proposed patient's definition of family and whānau differs from the above suggestions, their definition must be accepted if they are competent to

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

decide who their family or whānau is, or if they have nominated family or whānau in an advance directive.

The Act requires compulsory notifications at various stages of the assessment and treatment process to welfare guardians and to principal caregivers. Such people can be regarded as family or whānau for the purposes of consultation under section 7A, in addition to other family or whānau members. Note that 'principal caregiver' is more closely defined than family and whānau (see 2.4: 'Principal caregiver' above).

4.6.2 Prior competently expressed wishes

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

- crisis or treatment plans (see Standard 3.5 of the Health and Disability Services (Core) Standards – Continuum of service delivery; NZS 8134.1.3:2008)
- advance directives (see Right 7(5) of the Code of Rights)
- appointment of an enduring power of attorney (see Part 9 of the Protection of Personal and Property Rights Act 1988)
- personal orders under the Protection of Personal and Property Rights Act 1988, including an order to appoint a welfare guardian.

Clinicians and treating teams should enable patients to express their wishes when they are well. Frameworks that can facilitate this include, but are not limited to: treatment plans, advance directives (see Right 7(5) of the Code of Rights) and the mental health advance preference statements⁷⁸ (see also 2.1.2: 'Whether of a continuous or an intermittent nature' above). Clinicians and treating teams should ensure this information is included in the patient's notes so that they can take it into account in future decision-making if the person lacks mental competence. Teams should also enable discussion with family or whānau about such plans to increase the chances of acting on the patient's wishes that they expressed competently in the past.

4.6.3 Disputed definitions of family and whānau

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

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

The DAMHS will make this decision based on advice from the responsible clinician or another staff member who knows the patient or proposed patient. Other parties who could offer advice may include the patient's or proposed patient's principal caregiver,

⁷⁸ Southern Health. 2019. *Mental Health Advance Preferences Statement*. URL: <https://www.southernhealth.nz/getting-help-you-need/mental-health-and-addictions/mental-health-advance-preferences-statement> (accessed 24 July 2020).

welfare guardian, general practitioner, key worker, kaumātua, Māori health worker, cultural support staff, consumer advisors, non-governmental organisations or a district inspector.

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

4.7 What consultation is

4.7.1 Defining 'consultation'

In practical terms, consultation for the purposes of the Mental Health Act involves ongoing engagement between the health professional, responsible clinician (and treating team) and the family or whānau of the patient or proposed patient in a therapeutic process. Consultation is a two-way ongoing process and 'should not be limited to achieving formal obligations'.⁷⁹

The Act does not require the parties to agree or negotiate towards agreement as part of consultation. However, negotiations and agreement might occur as the tendency in consultation is for the parties to work towards consensus.⁸⁰

4.7.2 Consulting with the patient or proposed patient

A mental health practitioner or responsible clinician must discuss with the patient or proposed patient to find out their views about consultation with their family or whānau. It is important that a mental health practitioner or responsible clinician is open to connecting with alternative contacts before consultation occurs.

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

⁷⁹ Te Arawhiti. 2018. *Guidelines for engagement with Māori*. URL: <https://tearawhiti.govt.nz/assets/Maori-Crown-Relations-Roopu/6b46d994f8/Engagement-Guidelines-1-Oct-18.pdf> (accessed 24 July 2020).

⁸⁰ *Wellington Airport v Air New Zealand* [1993] 1 NZLR 671.

4.8 How to consult



Mā te rongo, ka mōhio
Mā te mōhio, ka mārama
Mā te mārama, ka mātau
Ma te mātau, ka ora

The above whakataukī (proverb) uses mātauranga Māori (Māori knowledge) concepts to achieve wellbeing. It is translated as: through listening comes awareness; through awareness comes understanding; through understanding comes knowledge; through knowledge comes life and wellbeing. This whakataukī can be applied to mental health services (or health services more broadly), suggesting that enhancing a person's informed decision-making empowers the individual and/or group.

4.8.1 Consulting family and whānau

A mental health practitioner or responsible clinician must use their discretion to decide how much information to disclose to the family or whānau so that the family or whānau can make informed responses to the proposed course of assessment or treatment.

As the courts have described it, meaningful consultation can be achieved through a variety of mediums (for example, in person or through teleconference). The courts have also identified the following stages in consultation, in which the party that is required to consult:

- begins consultation in the formative stages of a process by notifying affected or interested parties of a proposed decision or action
- provides the affected or interested parties with a reasonable amount of time in which to respond to the notification (the time involved will depend on the urgency of the action)
- may have a working plan in mind that they inform the affected or interested parties about, while keeping an open mind and being ready to adapt if that is required
- provides the affected or interested parties with a reasonable opportunity to form and state their views in a safe and open environment
- considers properly the representations of the affected or interested parties before making a decision
- notifies the affected or interested parties of the outcomes of the consultation.

To be meaningful, consultation must occur before the mental health practitioner or responsible clinician makes a decision. Discussions after a decision has been made are information sharing rather than consultation.

Consulting family and whānau as part of the assessment and treatment process is generally ongoing to allow views to change as new information is shared. If a significant period has passed or new information has come to light since a consultation, the mental health practitioner or responsible clinician should not rely on that consultation and instead should begin a new consultation.

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

4.8.2 Consulting Māori

Māori hauora and wellbeing encapsulate an 'interwoven relationship' between whānau, hapū and iwi.⁸¹ The Act's general emphasis on the individual patient or proposed patient is in conflict with 'whanaungatanga', a concept of interdependence and interconnectedness between all members of the whānau, including the tangata whai ora.⁸² However, section 5(2)(a) and (b) of the Act emphasises the importance of these connections by requiring services to be delivered with proper recognition of these relationships, and the importance of these relationships to an individual's wellbeing (see 4.1: 'Cultural identity' above).

A mental health practitioner or responsible clinician should not solely make decisions about the interests of Māori individuals and/or whānau. Whenever possible, they should work alongside Māori health workers, kaumātua, cultural support staff, tangata whai ora advocacy services, Māori advisory committees or other Māori providers of services to tangata whai ora. For concerns about privacy requirements, see 4.1.2: 'Recognition of family and whānau' above.

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

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

Every whānau needs recognition and to be able to participate in care, assessment and treatment processes in a culturally safe environment. Māori and non-Māori professionals should aspire to work with whānau to develop understandings meaningful to that whānau specifically.⁸³

⁸¹ Elder H. 2019. Te puna a hinengaro: he tirohanga ki a aheinga the wellspring of mind: reflections on capacity from a Māori perspective. In I Reuecamp, J Dawson (eds) *Mental Capacity Law in New Zealand*. Wellington: Thomson Reuters.

⁸² 'Tangata whai ora' means 'the person who is seeking wellness'.

⁸³ Elder and Tapsell, 2013, above note 49.

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

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

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

In practice, family and whānau consultation can reflect the five principles of Te Tiriti o Waitangi – tino rangatiratanga, equity, active protection, options and partnership – as the following examples illustrate.

- Tino rangatiratanga (self-determination), which has some features in common with supported decision-making, may help a patient or proposed patient engage in self-determination and live by their values.
- Equity might require the responsible clinician to be mindful of how connection with family or whānau influences the health outcomes of a patient or proposed patient. That includes considering both the therapeutic value of engaging a support network and the potential to harm a socially isolated patient.
- Active protection might see that a responsible clinician protects the relationships a patient or proposed patient has with their family or whānau and other support networks.
- Options, similar to tino rangatiratanga in the above example, might offer the patient or proposed patient what they want for their treatment and how they wish their family or whānau to be engaged. This may include considering meeting at a place that is convenient for both the clinician and family or whānau, which can help address access barriers such as travel and time.
- Partnership may involve the responsible clinician, patient or proposed patient, and their family or whānau continually working together and respecting one another's views, for the benefit of the patient or proposed patient.

These examples are only some ways in which consultation can reflect Te Tiriti o Waitangi principles. We encourage clinicians to work with Māori and kaupapa Māori services to seek out best-practice methods so that the care provided is a good fit for the person in front of them.

4.8.3 Consulting other cultures and identities

A mental health practitioner or responsible clinician must give similar consideration to the cultural needs of a patient or proposed patient, and their family or whānau, when they identify as someone from a Pacific or another culture or ethnicity.

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

4.9 Reasons for not consulting

4.9.1 'Best interests'

The central feature of the 'best interests' concept is that the interests of the patient or proposed patient come ahead of anybody else's interests. 'Best interests' is an expression used in the Act (for example, in section 19 and clause 2 of Schedule 1).

Be mindful when a patient or proposed patient has capacity to make the decision about consulting their family or whānau and the extent of any such consultation, or they have a valid advance directive that addresses this issue, and they refuse consent to such consultation. A mental health practitioner or responsible clinician should respect the decision of a patient or proposed patient to consult (or not) with family and whānau.

If a patient or proposed patient does not wish to consult with family or whānau, but there are certain aspects through their treatment journey that is important for the family or whānau to know, the responsible clinician may wish to work with the patient on establishing the connection between them and their family or whānau. In some circumstances, there may be grounds under the Privacy Act 2020, Health Information Privacy Code 2020, Health Act 1956 or other legislation for disclosing certain information to family and whānau in the absence of consent.

For example, if family or whānau will be providing the ongoing care of a discharged patient, and the discharged patient refuses consent to the disclosure of information to their family/whānau, information relevant to that patient's care by family or whānau can still be disclosed in accordance with section 22F of the Health Act 1956 and rule 11(2)(a) of the Health Information Privacy Code 2020. Additionally, it may be appropriate to disclose information to family and whānau where it is necessary to prevent or lessen a serious threat to public health or public safety, or the life or health of the individual concerned or another individual (rule 11(2)(d), Health Information Privacy Code 2020).

Where a patient has impaired capacity to make the decision on consultation with family and whānau, a mental health practitioner or responsible clinician must consider all relevant clinical and personal information in deciding whether to consult with the person's family and whānau. This information includes:

- the mental state of the patient or proposed patient
- the extent and likely duration of the impaired capacity of a patient or proposed patient to make decisions about their care

- any advance preferences statement the patient or proposed patient may have made
- their will and preferences with respect to the issue of consultation, and their reasons for refusing to consent to consultation with family and whānau
- the impact of overriding their refusal of consent on their treatment and mental health
- why the patient or proposed patient wants their family or whānau excluded
- the clinical and family or whānau history of the patient or proposed patient (including, for example, any family violence)
- any previous contact the patient or proposed patient has had with other mental health service providers
- how likely it is that the family or whānau has information that is not available from other sources.

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

A mental health practitioner or responsible clinician must have reasonable grounds for deciding that consultation with the family or whānau of a patient or proposed patient is not in their best interests (under section 7A(3)(b) of the Act). For example, it is important to establish whether any family violence or coercive control dynamics may be present in the family or whānau and, if so, what the impact may be.

If clinicians decide that consultation is not in the best interests of the patient or proposed patient, they should report the reasoning behind that decision. Simply writing 'not in best interest' or 'not practicable' is not sufficient.

For more practical information about involving families and whānau in the assessment and treatment processes, see: RANZCP. 2000. *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes*. Wellington: Ministry of Health.

If the mental health practitioner or responsible clinician decides consulting the family or whānau is not in the best interests of the patient or proposed patient, they must document this decision in the clinical file and Mental Health Act reports, along with their reasons for not consulting. They must take into account that:

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

4.9.2 'Reasonably practicable'

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

Other jurisdictions have considered the term 'practicable' in relation to family involvement in mental health care.⁸⁴ The use of the term acknowledges that, for various reasons, there are circumstances in which we must be content with less than the ideal, and the degree of compromise calls for judgement and common sense.

For this reason, when deciding whether consultation is 'not reasonably practicable' the mental health practitioner or responsible clinician needs to consider objectively whether consultation is feasible. They may consider:

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

For assessments occurring after hours, the time of day is not necessarily a reason for deciding against consulting family or whānau. An after-hours assessment would invariably be an urgent assessment in which family or whānau consultation may be highly relevant to the immediate safety and risk issues. If family or whānau were not present when the proposed patient was uplifted for an assessment, they may be waiting anxiously for an outcome of the assessment.

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

If in doubt, a clinician can always check with the family or whānau as to what they also consider 'reasonably practicable'. For example, it would be presumptuous to conclude that it is not reasonably practicable to call the family or whānau in the middle of the night or that they would be unhappy about that. The clinician can resolve these concerns by consulting the family or whānau as to what they would prefer.

From 1 July 2020, the Director of Mental Health requires that any time a responsible clinician records family or whānau consultation was not conducted because it was 'not reasonably practicable', they must document the reasons for this in the assessment form and provide a record of this to the relevant DAMHS. The DAMHS is expected to provide this record to district inspectors and the Director of Mental Health as requested.

⁸⁴ *R (on the application of E) v Bristol City Council* [2005] EWHC 74 (Admin).

Where planned assessments occur under section 76 of the Act, it will rarely be justifiable to record that family or whānau were not consulted because it was 'not reasonably practicable' as these assessments can be scheduled and arranged in advance in a manner that accommodates the needs of the family or whānau to participate. If a clinician records family or whānau consultation was 'not reasonably practicable' for a section 76 assessment, the Director of Mental Health requires the clinician to record the details and an explanation of why the consultation was 'not reasonably practicable' and to provide that record to the DAMHS.

For more information about supporting families and whānau with mental illness, see: Ministry of Health. 2015. *Supporting Parents, Healthy Children*. Wellington: Ministry of Health. These guidelines offer strategies and services for the mental health and addiction sector workforce when working with families and whānau at practice, service and organisational levels. Through these approaches, the guidelines promote the voices and realities of families and children living with mental illness and substance use while aiming to strengthen and protect their wellbeing. Visit the Ministry of Health website (www.health.govt.nz) and search for 'supporting parents, healthy children' to download the guidelines and access extra resources.

5 Part 1: Compulsory assessment and treatment

If less restrictive mental health interventions have failed and a person appears to be mentally disordered, compulsory assessment under Part 1 of the Act may be appropriate. Any person can apply for assessment under section 8 of the Act, provided they meet the criteria in sections 8A and 8B. A section 8A application can only be made after a section 8B certificate is completed but, in practice, the mental health practitioner⁸⁵ might initiate the 8B and then seek an 8A from the concerned family or whānau as soon as possible.

For the purpose of section 8B assessments section 2 of the Act defines mental health practitioner to mean:

- a) a medical practitioner; or
- b) a nurse practitioner; or
- c) a registered nurse practising in mental health

Medical practitioner means, a health practitioner who is, or is deemed to be, registered with the Medical Council of New Zealand continued by **section 114(1)(a)** of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of medicine

Nurse practitioner means, health practitioner who is, or is deemed to be, registered with the Nursing Council of New Zealand continued by **section 114(1)(a)** of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions; and holds a current practising certificate

Registered nurse practising in mental means a health practitioner who is, or is deemed to be, registered with the Nursing Council of New Zealand continued by **section 114(1)(a)** of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice includes the assessment of the presence of mental disorder as defined under this Act and holds a current practising certificate

It should be noted that the act does not place conditions on either medical practitioners or nurse practitioners which means these practitioners do not need to be working within mental health services to undertake assessments. This includes but is

⁸⁵ For the purposes of section 8B, a mental health practitioner can only be a medical practitioner, nurse practitioner or registered nurse practising in mental health.

not limited to, general practitioners, nurse practitioners working in primary care or rural settings and medical practitioners working within specialty medical services such as emergency departments.

As the application process is a complex and significant intervention, the Ministry recommends that anyone concerned about a person's mental health contact a crisis assessment team and seek the help of a DAO. The Ministry maintains a list of mental health crisis phone numbers on its website.⁸⁶

See Figure 2, for a flowchart of the process from application for assessment to application for compulsory treatment order.

5.1 Threshold for applying for compulsory assessment

The Act sets a lower threshold for making an initial application for compulsory assessment than for making a compulsory treatment order. At each stage of the assessment process, however, a mental health practitioner has the opportunity to release a person from further assessment if the mental health practitioner is of the opinion that the person is not mentally disordered. The following sections provide those opportunities (with emphasis added to the quotes from the Act; see also Figure 1 for a summary).

- Under section 8B(4)(b) of the Act, a nurse practitioner, medical practitioner or registered nurse working in mental health must 'consider that there are **reasonable grounds** for believing that the person **may be suffering from** a mental disorder' before issuing a certificate to accompany an application for compulsory assessment.
- Under section 10(4) of the Act, the mental health practitioner issuing a certificate of preliminary assessment must consider that there are '**reasonable grounds** for believing that the proposed patient **is** mentally disordered'. Section 10(3) of the Act provides the option that a proposed patient is **free** from further assessment and treatment if the mental health practitioner is of the opinion that the person is **not** mentally disordered. This is an important part of the assessment process and decision-making needs to be rigorous and holistic, considering all aspects of the proposed patient.
- Under section 12(4) of the Act, the responsible clinician issuing a certificate of further assessment must consider that 'there remain **reasonable grounds** for believing that the patient **is** mentally disordered'. Section 12(3) of the Act provides the option to **release** a patient from compulsory status if the responsible clinician is of the opinion that the patient is **not** mentally disordered.
- Before issuing a certificate of final assessment, the responsible clinician must determine whether a patient **is** or **is not** fit to be released under section 14(1)(a) and 14(1)(b), respectively. Following *Waitemata Health*, this means that the responsible clinician must **believe** that the patient **is** or **is not** mentally disordered.

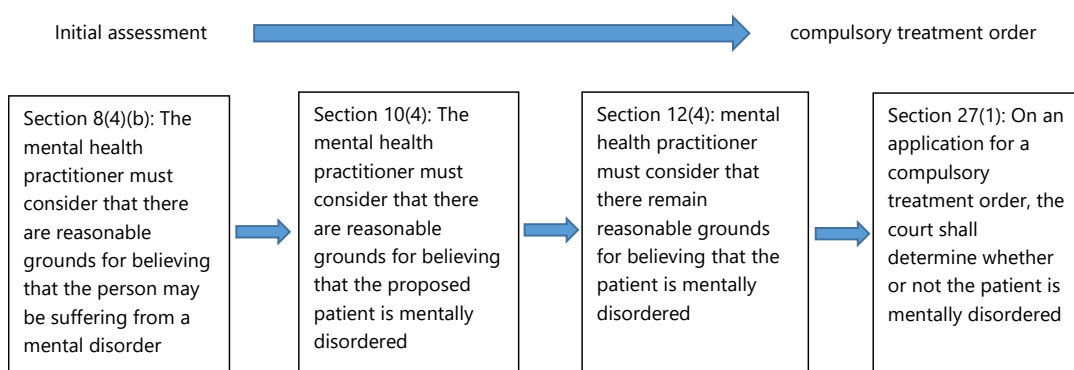
⁸⁶ Ministry of Health. Crisis assessment teams. URL: www.health.govt.nz/yourhealth-topics/health-care-services/mental-health-services/crisis-assessment-teams (accessed 26 July 2020).

- Before a compulsory treatment order can be issued under section 27(1) of the Act, the court must 'consider whether or not the patient **is** mentally disordered'. Section 27(2) of the Act provides that if the court considers a patient is not mentally disordered, the patient will be released from compulsory status forthwith (see also 6.9: 'Release from compulsory treatment order'). Section 27(3), on the other hand, provides that if the court considers that the patient is mentally disordered, it must determine whether or not, considering all the circumstances of the case, it is **necessary** to make a compulsory treatment order.

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

If at any time the responsible clinician becomes concerned that there may have been insufficient grounds for compulsory assessment, the next stage of the compulsory assessment process should be undertaken. A new assessment will override earlier legal errors if the legality of the patient's detention is called into question,⁸⁷ therefore preventing a successful application for a writ of *habeas corpus*.

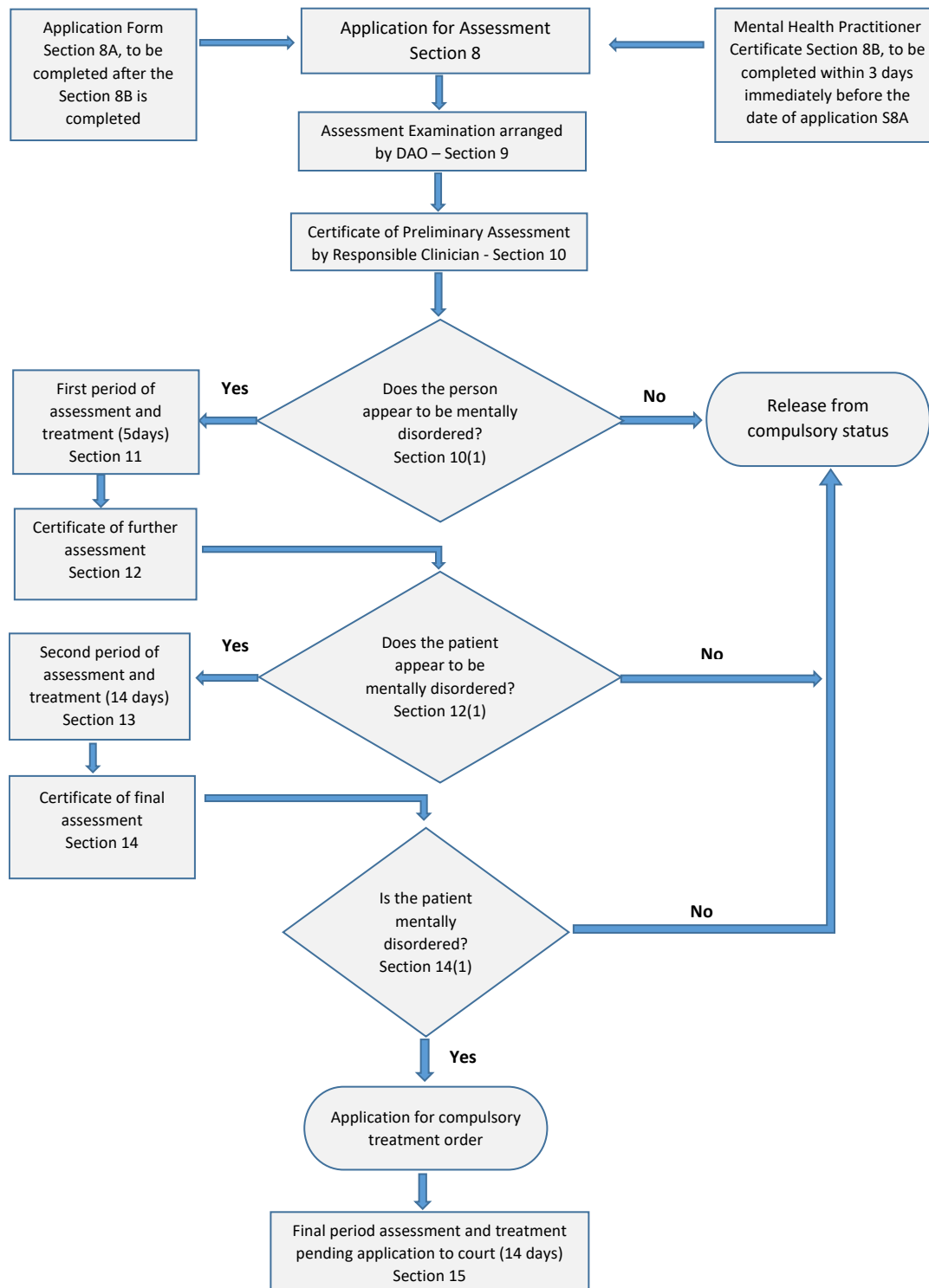
Figure 1: Sections of the Mental Health Act that certify the likelihood of a mental disorder from initial assessment to compulsory treatment order



As Judge P von Dadszen determined, a five-day assessment period under section 12 cannot be truncated for administrative convenience (such as lack of staff or resources over a weekend). The decision to truncate the section 12 assessment should be based on good clinical reasoning and should be communicated with the patient clearly and documented in their clinical file.

⁸⁷ *B v Auckland DHB* [2010] NZCA 632; [2011] NZAR 135.

Figure 2: Flowchart of the process from application for assessment to application for compulsory treatment order



5.2 Applications for assessment: duly authorised officers

The Act states that an application is made under section 8A when the DAMHS receives a filled-out application form that is accompanied by a certificate issued under section 8B. The section 8B certificate states the date of the examination, which must be within the three days prior to the date of the 8A application. Once an application is made, a DAO may take all reasonable steps to facilitate an assessment examination under section 40(2)(a).

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

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

5.3 Assessment examinations

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

5.3.1 Section 9(2) requirements for assessment arrangements

Section 9(2) of the Act details the arrangements required under section 9(1) of the Act. These include a requirement to give the proposed patient a written notice explaining the purpose of the examination and detailing the place and time of the assessment and the person conducting it (section 9(2)(c)). Section 9(2)(d) of the Act ensures that the notice given under 9(2)(c) is explained to the proposed patient in the presence of a member of the proposed patient's family or whānau or a caregiver in relation to the proposed patient or another person concerned with the welfare of the proposed patient. Section 9(2)(e) of the Act ensures, where necessary, that appropriate arrangements are made to transport the proposed patient at the right time to the place where the assessment examination will be carried out and, where necessary or desirable, to have an appropriate person accompanying the proposed patient.

The DAMHS or DAO may not always be able to perform these functions personally but must ensure that necessary arrangements are made appropriate to the circumstances, noting whether the situation is urgent. For example, if a mental health practitioner is acting under section 110 of the Act (powers of mental health practitioner where urgent assessment is required), a phone call to the DAO or DAMHS is sufficient to decide who will carry out the assessment and where. The DAO can ask the mental health practitioner to give the section 9(2)(c) notice to the proposed patient and explain what is to occur and their rights (see Chapter 10).

Written information does not need to be provided using the section 9 form. The proposed patient should be given as much detail as practicable. The clinician must make a reasonable judgement as to how much disclosure is practicable in the circumstances.

In making the necessary arrangements for an assessment examination under section 9(1) of the Act, a DAO may contact other health services (such as a primary health care provider) to obtain information relevant to the assessment. Legislation related to information privacy (namely, the Health Information Privacy Code 2020, the Privacy Act 2020 and the Health Act 1956) permit DAOs to collect such information and permit health services to disclose it to DAOs.⁸⁸

If the proposed patient is assessed as not being mentally disordered, the DAO and other clinical staff of the mental health service concerned should take whatever further action is required to help that person. This help will include:

- continuing to provide services to a patient who accepts them voluntarily
- helping with transport from the place of assessment (if the person has been transported to the assessment) back to their home or to some other agreed place.

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

It is mandatory for an explanation of the purpose of the assessment to take place in the presence of a support person under section 9(2)(d). While non-compliance with this section has previously led courts to grant applications for *habeas corpus*,⁸⁹ the Court of Appeal has indicated that such a breach is not enough to justify nullifying the assessment process by granting the writ if the assessor has attempted to comply with the requirement.⁹⁰

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

⁸⁸ Section 22F of the Health Act 1956 states that a provider who holds health information must disclose that information to another person who is providing or is to provide health or disability services to a person.

⁸⁹ *Keenan v DAMHS* [2006] 2 NZLR 572; *Chu v District Court at Wellington* [2006] NZAR 707.

⁹⁰ *Sestan v DAMHS, Waitemata District Health Board* [2007] 1 NZLR 767.

The mental health practitioner undertaking the assessment must offer to organise for a support person who the applicant knows, such as a family or whānau member, caregiver or friend, to attend the assessment if such a person is available. If no such person is available, the mental health practitioner should engage an independent person not involved in the application or assessment and treatment process. This person should not be a mental health professional (Justices of the Peace (JPs) are available for this purpose).

Audio-visual link (AVL) technology can be used to fulfil the requirements of section 9(2)(d) unless it is not possible. If full AVL technology is not available in the circumstance, a teleconference is permissible **in this situation only**.

Care must be taken to ensure that all parties can adequately participate in the interaction, and that all parties have understood the information provided.

Provided this process is undertaken in good faith, it is unlikely to prejudice the validity of the application as other opportunities for clinical and judicial reassessment are available under the Act.⁹¹ If a proposed patient strongly indicates that they do not want to comply with the requirement, their right to privacy should be respected.⁹² Additionally, in some situations it may be unsafe to engage a support person.

5.3.3 A mental health practitioner must conduct a section 9(3) assessment examination

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

'Psychiatrist' is defined in section 2 of the Act as 'a medical practitioner whose scope of practice includes psychiatry'. A medical practitioner holding 'scope of practice' in any specialty must have completed vocational training and a postgraduate qualification approved for or relevant to the scope of practice.⁹³ Registrars are registered in a general scope of practice and do not fall under this definition. A nurse practitioner is a health practitioner who is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice permits the performance of nurse practitioner functions and holds a current practising certificate.

The Act does not define 'reasonably available'. The expertise that is 'reasonably available' in a well-staffed urban centre may be very different to that in a more isolated

⁹¹ *Sestan*, above note 90, paragraphs [42]–[55].

⁹² *Sestan*, above note 90, paragraph [54].

⁹³ Medical Council of New Zealand. 2019. Scopes of practice. URL: <https://www.mcnz.org.nz/registration/scopes-of-practice/> (accessed 27 July 2020).

rural area. Nevertheless, some consistency in the matter is expected. A decision about the expertise that is 'reasonably available' should consider the following context:

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

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

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

- after hours when no psychiatrist is scheduled on the duty roster (for example, in small district mental health services where registrars and medical officers (special scale) are the only roles on the duty rosters)
- when the psychiatrist is absent for other reasons (such as ill health) and cannot be replaced by another psychiatrist
- when the psychiatrist is involved in other urgent work preventing them from attending the assessment in a timely manner and they cannot be replaced by another psychiatrist
- when the psychiatrist is too far away to attend the assessment in a timely manner (for example, in district mental health services that cover a large geographical area).

Whenever possible (and particularly in the last two examples), the mental health practitioner conducting the assessment should discuss the particulars of the case over the telephone with the psychiatrist. They should document this discussion in the clinical file and in the Mental Health Act clinical report.

'Suitably qualified' is not defined. For example, when deciding on making an appointment under section 9(3), the Director of Mental Health will take into account the training and experience of the practitioner. In a more difficult case that requires a fine degree of judgement, a more experienced senior practitioner with a greater level of expertise is needed. If substance use is also involved, consultation with a suitably qualified addiction practitioner may be appropriate.

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

The Act requires that copies of certificates completed following examinations at various stages of the compulsory assessment and treatments process (sections 10, 12, 14, 29(3) and 76) be sent to key people. These people are: the patient; any welfare guardian of the patient; the applicant for assessment; the patient's principal caregiver and the primary care provider who usually supports the patient; and a district inspector. Note

that these certificates or documents can be emailed to these people when required: section 133(3)(c) states that 'some other electronic means' can be used. Although post has traditionally been used, it may no longer be the most appropriate method of communicating with patients or others mentioned in the Act.

Responsibility for delivering certificates to patients in acute units lies with the patient's responsible clinician.

5.3.4 Reapplication following release from compulsory assessment

Section 10(3) of the Act provides that a further application under section 8A may be made at some time in the future. In some circumstances, a further application may be required very soon after the first assessment. No time limit is specified. A reapplication should be judged on the clinical and other information to hand. It should take into account the previous assessment made under section 10(3) of the Act, and the circumstances of the assessment that found the individual not to be mentally disordered at that time.

5.4 Further assessment and treatment periods

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

Both sections 11 and 13 of the Act refer to the assessment and treatment periods as 'commencing with the date on which the patient receives the notice and ending on the close of the [XX] day after that date'. The 5- and 14-day periods should be calculated exclusive of the day on which the notice is given to the patient.⁹⁴ For this reason, we recommend adopting the interpretation in the following example.

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

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

⁹⁴ *Re DI* [1996] NZFLR 713.

If, at any time during the first period (section 11(6)) or second period (section 13(6)), the responsible clinician considers that the patient is not mentally disordered and is, therefore, fit to be released from compulsory status, the patient must be immediately discharged. If there are good clinical reasons for truncating the 5- or 14-day assessment periods, it is not necessary to let them run their full course.

5.5 Leave during the assessment and treatment process

Sections 11(5) and 13(5) of the Act enable a responsible clinician to allow a patient subject to compulsory inpatient assessment a short period of controlled leave ('trial leave') in the community, or to allow leave on compassionate grounds (such as to attend a tangihanga). Section 13(5) also applies when a responsible clinician has applied for a compulsory treatment order. When a certificate is completed following a responsible clinician's examination, we suggest providing an easy-to-read written notice that explains the certificate's consequences.

If the leave is for eight hours or less between 8.00 am and 10.00 pm, the Act requires it to be recorded (along with the terms and conditions of leave) in the patient's clinical records (sections 11(5)(a) and 13(5)(a)). The patient's contact details while on leave should also be recorded.

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

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

Under sections 11(5) and 13(5) of the Act, a clinician can grant leave on such terms and conditions as they think fit. If the patient is well enough to receive leave but the clinician suspects that their state of mind may deteriorate during that time, a condition of the leave could be that if the patient's state of mind deteriorates, they must return to hospital with the assistance of a DAO.

5.6 Section 14: Certificate of final assessment

Section 14(4) of the Act governs the process of applying to the court for a compulsory treatment order. The responsible clinician must personally form the opinion that the patient is not fit to be released from compulsory status.⁹⁵

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

A second health professional's evidence should do more than merely address the legal criteria of the Act. The evidence should also provide a comprehensive global view of the patient's current presenting mental health problems. The second health professional will most often be a registered nurse practising in mental health. For guidance for nurses on report writing, see: Office of the Director of Mental Health and Addiction Services and Te Ao Māramatanga New Zealand College of Mental Health Nurses. 2012. *Guidelines for Mental Health Nursing Assessment and Reports*. URL: <https://www.nzcmhn.org.nz/files/file/22/Guidelines%20for%20MH%20assessments%20and%20reports%20January%202012%20signed.pdf> (accessed 27 July 2020).

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

- comments on the patient's history of contact with mental health services, including severity of illness and response to treatment
- issues of substance use
- previous admissions under the Act, Mental Health Act 1969, Criminal Justice Act 1985, Criminal Procedure (Mentally Impaired Persons) Act 2003, Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Protection of Personal and Property Rights Act 1988, Alcoholism and Drug Addiction Act 1966 or Substance Addiction Act
- comments on cultural, religious, gender or other factors to do with the patient's identity (including advice on whether an assessment has been conducted on those realms)
- advice on family or whānau and social support
- proposals for treatment, including information on community services (if applying for a community compulsory treatment order)

⁹⁵ LB [1994] NZFLR 60.

- justification of how the patient meets both limbs of the definition of 'mental disorder'
- any known specific risk and protective factors
- issues likely to be challenged in a defended hearing.⁹⁶

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

Following the final assessment, the patient may be held for up to 14 days after the time at which the second period would have expired (section 15(1)). This means that the maximum period for which a person can be held for assessment consists of a 5-day first period, a 14-day second period and 14-day final period, totalling 33 days. This period may only be extended by the order of a court (section 15(2)).

5.7 Section 16: Review by a judge

Section 16 of the Act allows the patient to request a Judge to review the patient's condition while the assessment process is under way. If the Judge is 'satisfied' that the patient is fit to be released from compulsory status, the Judge shall order that the patient be released from that status forthwith. If not, the process of assessment continues. The process outlined in section 16 of the Act can be invoked at any point after a certificate of preliminary assessment requiring further assessment and treatment of the patient has been issued.

It is important to note that the issuing of a section 14 certificate under the Act does not revoke a patient's right to be examined by a Judge pursuant to section 16⁹⁷. An applicant has a right to be examined by a Judge "as soon as practicable" if such an application is made to the court. The issuing of a section 14 certificate of final assessment by the responsible clinician does not prevent a section 16 hearing being held after that date.

During the assessment process a Judge has limited discretion in deciding whether or not to grant a review of a patient's condition. The first application for a section 16 hearing in an assessment period must be heard by a Judge. However, if the application is the second or subsequent during the same assessment period, a Judge may decide not to grant a review. In making this decision the Judge must regard any evidence that indicates the patient's condition has not changed since the last review (section 16(1C)).

It falls to the person seeking the review and release from compulsory status to satisfy the Judge that the patient is fit to be released from that status. In such a review, the Judge is unlikely to have available the same amount of evidence as would be obtained at the full hearing.

A Judge must consider the evidence of both the responsible clinician and 'at least 1 other health professional involved in the case' when determining an application for

⁹⁶ McCarthy S, Simpson S. 1996. *Running a case under the Mental Health Act 1992 and related legislation*. Paper presented at New Zealand Law Society Seminar, May–June, pp 14–16.

⁹⁷ CIV-2021-409-000094 NZHC 2465 [20 September 2021].

review (section 16(4)). The second health professional will most often be a registered nurse practising in mental health.

Where a patient under a community treatment order has been directed to be treated as an inpatient under section 29(3) of the Act, it is interpreted that following a Judge's determination after a court review, a patient could be found fit to be released from the Act and no longer subject to a community treatment order.

Section 16 reviews are an important safeguard that reflects principles endorsed by the United Nations⁹⁸. That is, to ensure that a judicial or independent and impartial review body, is established by law, to review the admission and detention of an involuntary patient, as soon as possible after admission or detention a person as a voluntary patient.

The power of a District Court Judge to find that a patient is "fit to be released from compulsory status" must be based solely on the state of health of the patient and does not allow a consideration of the legality of detaining the patient in hospital⁹⁹. Section 16 does not provide reviewing judges with the power to release a patient on any ground other than they are no longer mentally disordered¹⁰⁰.

Section 6 of the Habeas Corpus Act 2001 permits applications for writ of *habeas corpus* to challenge the legality of a person's detention. Applications for a writ of *habeas corpus* must take precedence before the High Court. The hearing of the application must occur no later than three working days after the application was filed (section 9 of the Habeas Corpus Act 2001). If lawful detention is not substantiated, the court must order the release of the patient.

⁹⁸ United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, principles 16(2) and 17(2)).

⁹⁹ Re B W A [Mental Health] (1994) 12 FRNZ 510, In the matter of B W A [1995] NZFLR 321.

¹⁰⁰ Sestan v Director of Area Mental Health Services Waitemata DHB [2007] 1 NZLR 767, at para 53.

6 Part 2: Compulsory treatment orders

A court makes a compulsory treatment order under section 28 of the Act. It will only make such an order when a patient is mentally disordered and it considers that the order is necessary to compulsorily treat the patient.

The Review Tribunal¹⁰¹ made the following observations:

... the question of whether or not an order is necessary serves to expose the issue of whether or not serious dangerousness or seriously diminished capacity of self-care are present in terms of the second limb of the mental disorder definition. If compulsory treatment is necessary to address concerns of dangerousness or diminished capacity of self-care, then that confirms that such danger or diminished self-care is present in terms of the second limb of the mental disorder definition.

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

6.1 Scope of a community treatment order

'A community treatment order shall require the patient to attend at the patient's place of residence, or at some other place specified in the order, for treatment by employees of the specified institution or service, and to accept that treatment' (section 29(1)).

The Act does not define treatment, but it must be 'treatment for mental disorder'. Before making such an order, the court must be satisfied that the patient can be provided with 'care and treatment on an outpatient basis that is appropriate to the needs of the patient' (section 28(4)(a)).

The following sections of the Act outline the powers to enforce compliance with the order.

- Section 29(1): The patient is required to attend and is 'required to accept' treatment for mental disorder at the direction of the responsible clinician during the first month of the community treatment order and after that time if the patient gives informed and written consent to the treatment (section 59(2)(a)). If the patient does

¹⁰¹ X, NZMHRT No 08/184, 13 February 2009.

not consent, treatment may still occur if a psychiatrist (other than the responsible clinician) appointed by the Review Tribunal considers that the treatment is in the patient's interests (section 59(1) and (2)(b); see Chapter 9).

- Section 29(2): Employees of the service specified in the order have the power to enter the specified place for the purpose of treating the patient.
- Section 40(2)(a): A DAO may take 'all reasonable steps' to take the patient to the place where they are required to attend for treatment.
- Section 41(5): The Police may be called to assist and may use necessary force to take the patient to the place where they are required to attend for treatment (see section 122B).
- Section 113A(4)(a): A warrant may be issued authorising Police to take a patient who refuses to attend to the place specified for treatment.

The scope of treatment should be clearly specified in the order (see 6.3: 'Terms of a community treatment order' below). A treatment plan may include a specific residential requirement, but this does not amount to a power to detain at the residence (see 6.2: 'Residence requirements under community treatment orders' below). In spite of the powers to enforce compliance with treatment as listed above, clinicians are encouraged to work with the individual and their family or whānau about what 'treatment for mental disorder' involves and what is the best way to do this to encourage compliance and support wellness.

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

6.2 Residence requirements under community treatment orders

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

The boundary between inpatient and community facilities is becoming increasingly blurred. For example, community facilities may be planned to provide a high level of care equivalent to that provided in a hospital setting. Although some residential settings may provide a high degree of supervision, a community treatment order is not a basis for, what is in practice, detention in a community facility without legal backing. A clear distinction must be maintained between an inpatient order (under which detention for treatment in a hospital mental health unit is authorised) and a community treatment order (under which detention in a hospital mental health unit is not authorised, except for short periods under section 29(3)(a)).

A responsible clinician has no statutory power to direct where a patient must live in the community.¹⁰² However, in making a community treatment order, a judge can specify that part of a patient's treatment can include supervision and monitoring that may only be provided in a particular type of residential facility, although this must not amount to detention in practice. For this reason, there is a strong need for a responsible clinician to clearly specify the terms and conditions of a community treatment order (a need that applies equally to leave for inpatients under section 31) when they apply to a court for such an order. Moreover, a responsible clinician can direct where a special patient must live in the community (not to be confused with detention) if it is a condition of the leave of absence for ministerial long leaves.

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

6.3 Terms of a community treatment order

The Act requires that the community treatment order specifies the place where the patient will attend, and the service or institution whose employees are providing the treatment. We also recommend that the application for the treatment order specifies the proposed treatment plan, in order that the court may make an order based on a clear plan of treatment.

When making an application, the responsible clinician should state in writing exactly what they are seeking in the proposed order. In particular, they should set out:

- the proposed treatment (medication or other treatment) that they consider necessary¹⁰³
- the type or method of treatment as the patient's condition changes
- the location where treatment will take place
- the service(s) or institution(s) responsible for providing the treatment
- monitoring arrangements that will be put in place
- an indication of the services and support that will be available to meet the needs of the patient, additional to those specified as compulsory.

¹⁰² *Department of Health v D* (1999) 18 FRNZ 233; [1999] NZFLR 514.

¹⁰³ If it is likely that treatment will need to vary during the time of the order, the clinician should specify this as far as possible. It is best not to name particular drugs or dosages, as medication may need to be altered. The description needs to include enough flexibility to allow a reasonable degree of change.

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

If the patient does not follow the specified terms of a community treatment order, this may be sufficient grounds to require the use of an enforcement power, an inpatient admission or a reassessment. There is no need to wait for the patient to become a serious danger to self or others, or to seriously diminish in their capacity for self-care, if a responsible clinician recognises early warning signs of relapse are emerging because the patient is not keeping to the compulsory treatment.

6.4 Voluntary admissions during the term of a community treatment order

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

- An inpatient admission during the term of a community treatment order, when the provisions of section 29(3)(a) or (b) do not apply, should occur **only** with the patient's fully informed consent, preferably in writing. This requires consideration of the patient's capacity to give informed consent.
- Whenever a patient is admitted as a voluntary inpatient during the term of a community treatment order, a district inspector must be notified (section 29(6)(d)). The district inspector can then check that the patient consents to the admission.
- In line with the scheme of the Act, which provides for limited compulsory admissions of patients subject to community treatment orders (see 6.5: 'Compulsory admissions during the term of a community treatment order' below), we suggest that such an admission should normally be for no more than 14 days. After this time, the situation should be reviewed and consideration given to discharging the patient to the community and/or reassessing the patient under section 29(3) of the Act.
- If while the patient is admitted voluntarily, and they withdraw their consent or are unable to give consent at any time, clinicians should consider whether the patient should be reassessed under section 29(3) of the Act.

6.5 Compulsory admissions during the term of a community treatment order

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

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

In urgent situations, where particular treatment is necessary to save a patient's life, to prevent serious damage to their health or to prevent the patient from causing serious injury to self or others, it is not necessary to first obtain the opinion of a psychiatrist appointed by the Review Tribunal (section 62).

A direction for inpatient treatment for any patient on a community treatment order cannot be made more than twice in any six-month period. If a patient requires either one period of more than 14 days or more than two 14-day periods as an inpatient during any six-month period, the responsible clinician must reassess the patient in line with sections 13 and 14 of the Act. The two 14-day periods cannot be consecutive.¹⁰⁴

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

The responsible clinician must examine the patient and complete both the written notice directing a change to inpatient status under section 29(3)(b) and a section 13 form. Under sections 58 and 59, the patient must then accept such treatment for mental disorder as the responsible clinician directs. Where a patient is assessed under section 29(3)(a) for 14 days, then reassessed under section 29(3)(b), the legal result is a permitted inpatient assessment of up to 28 days. This outcome should be made clear to the patient.

¹⁰⁴ *Director of Mental Health Services v Brown* FC Middlemore MA048/156/00 24 October 2000.

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

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

From time to time, patients subject to a community treatment order may wish to travel either within Aotearoa New Zealand or overseas. Section 18(3) of the NZBORA gives everyone who is lawfully in Aotearoa New Zealand the right to freedom of movement and residence in Aotearoa New Zealand, and to exit and enter freely, with the exception of grounds prescribed by law.

The Act is silent on the issue of patients travelling outside New Zealand while subject to a compulsory treatment order, except for special and restricted patients. If a patient wants to travel outside of Aotearoa New Zealand, we advise that they discuss this with their responsible clinician and treatment team, who will need to assess the patient's fitness to travel – which most airlines require.

As it is possible that a patient may become unwell while overseas, a plan should be developed with the clinical team and family, whānau or close supports to mitigate any clinical risks associated with this. A patient cannot be treated under the terms of their community treatment order in another country. Becoming acutely unwell overseas could cause considerable distress to the patient and their family or whānau, and may result in their repatriation to Aotearoa New Zealand at considerable cost.

For domestic travel or if the patient wishes to relocate within Aotearoa New Zealand, depending on the circumstances, it may be appropriate to consider whether it is possible to make an arrangement with another service to temporarily transfer the patient's compulsory treatment, or whether the person can be discharged from their compulsory treatment order. We encourage taking a collaborative approach with the patient when they express a wish to travel, as this is consistent with least restrictive practice and supported decision making.

While section 18(3) of the NZBORA states that everyone has the right to leave Aotearoa New Zealand, section 113A of the Mental Health Act allows for the judge, registrar or DAMHS (section 113(3)) to issue a warrant for each patient (including both community and inpatient) or proposed patient who is refusing to attend a place for treatment. Where a warrant is issued, a constable can take the patient or proposed patient to the place specified in the warrant to ensure they continue the treatment.

6.7 Inpatient treatment orders

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

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

6.8 Inpatient leave

Section 31 of the Act provides for a patient's responsible clinician to grant leave for a period of up to three months, subject to conditions that the responsible clinician sets. This period may be extended by a further three months. Family or whānau or the principal caregiver should be informed when a clinician grants leave from the inpatient unit.

Inpatient leave can be granted for many reasons, most commonly to test whether a patient can readjust to community living. Patients can be granted leave to trial independent living or supported accommodation in community facilities at varying levels of care. Some patients may require a trial period in a facility with a high level of supervision and oversight. However, section 31 does not authorise detention in a facility.

The Act is unclear about when it is necessary to specify terms and conditions of leave in writing. This also does not prevent clinicians from communicating with the patient and their principal caregiver and family or whānau about proposed leave plans. We recommend that clinicians communicate such plans in person with each party, as well as by following up with a clear summary in writing. When practicable, the responsible clinician should complete a leave form in each of the following circumstances:

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

The patient, the patient's nominated person (principal caregiver, family or whānau member, or another person) who has oversight of their care, and the person in charge of the hospital should also be given a copy of the leave form, similar to the process outlined under 5.5: 'Leave during the assessment and treatment process' above.

6.9 Release from compulsory treatment order

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

Clinicians are permitted to disclose that a person has been or is going to be released from compulsory status to their principal caregiver.¹⁰⁵ This would be appropriate if the person's family or whānau, significant support network or principal caregiver is expected to be involved in the person's continuing care. If a clinician has early discussions with the patient and their support network to identify clearly what is needed when a patient is discharged, or what else can be reviewed in their care plan in order to achieve greater wellbeing, it may increase the person's chances of long-term recovery.

Section 35 provides that, when a person is no longer mentally disordered, they must be released from compulsory status 'forthwith'. Forthwith does not mean instantly, but as soon as reasonably practicable.¹⁰⁶ It is not justifiable to keep a person who is not mentally disordered under compulsory treatment while lengthy preparations are made for their release into the community; in most cases, release forthwith should occur on the day a person is found fit to be released.

¹⁰⁵ Rule 11(1)(g), Health Information Privacy Code 2020.

¹⁰⁶ *Scott v Ministry of Transport* [1983] NZLR 234 at 236, Cooke J.

6.10 Reassessment following release from compulsory treatment order

The threshold for reassessing a patient who was formally under a compulsory treatment order for a new term of compulsory treatment will vary depending on the history and circumstances of that person. A person with a long history of mental disorder with well-documented early warning signs of relapse may meet the compulsory assessment criteria as soon as those warning signs are detected. A responsible clinician need not wait for imminent danger to arise before reinitiating the procedures of the Act in such a case.¹⁰⁷ A recent release from compulsory status is not a barrier to compulsory reassessment.

If a former compulsory patient is not previously known to a mental health service, or if the early warning signs of relapse are not well defined, the responsible clinician may need to wait until it becomes more apparent that the patient meets the criteria for a mental disorder before reinstating the procedures of the Act.

6.11 Extension to compulsory treatment order

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

It is advisable that, during this time, the clinician consults with the family, whānau or whoever the patient's specified support network or person is. As 4.9.2: 'Reasonably practicable' notes above, because an assessment under section 76 of the Act is planned, there is an expectation that the needs of the family or whānau will be taken into account so that they are able to participate. If this consultation does not occur, clinicians are expected to record the reasoning behind the lack of consultation.

Following this consultation, the responsible clinician may then apply for an extension to the order. They must lodge their application with the court before the close of business on the last day of the order. An application for an extension is treated as if it is an application under section 14(4). If granted, an extension will take effect from the day after the date on which the order would otherwise have expired. Where an extension application has been lodged, interim provisions allow compulsory treatment to continue under section 15 until the court makes its decision on the application.

¹⁰⁷ *Re KMD*, NZMHRT 04/139, 27 April 2005.

If the court grants an extension, statutory time periods requiring action within a certain time from the making of an order are not reset. For example, section 59(1) requires patients to accept treatment as directed by their responsible clinician within the first month of an order, without consent or a concurring second opinion, but this section does not apply following an extension. Similarly, the requirement under section 76(1)(a) to perform a clinical review within the first three months of an order does not apply following an extension.

Note that the responsible clinician must conduct a section 76 review for every patient (other than a restricted patient, who is subject to a compulsory treatment order or subject to an order under section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003) no later than three months after the date of the order and no longer than intervals of six months after that.

In summary, currently as explained above every compulsory treatment order expires after 6 months unless a judge extends it for a further 6 months under section 34. If on any subsequent assessment the responsible clinician considers the person is still mentally disordered and applies to the court for an extension of the order, this additional extension will have effect indefinitely.

6.11.1 Additional guidance for the transition from indefinite treatment orders to the requirements of section 34A for 12-month extensions of compulsory treatment orders.

Indefinite treatment orders have been widely criticised as a serious breach of human rights and their elimination has been regarded as a significant policy reform that stakeholders and *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (November 2018) clearly called for.

Following commencement of the MH(CAT) Amendment Act 2021, indefinite compulsory treatment orders (CTOs) will be eliminated and will be replaced with a requirement for a 12-month extension (s34A), when a CTO has already been extended once pursuant to s34(2) of the Act. The commencement date for this new provision will be 29 October 2023.

Existing indefinite compulsory treatment orders (CTOs) will begin to expire on the anniversary date of when the CTO was extended indefinitely under section 34(4) (prior to 29 October 2023). That means that if a CTO had been extended indefinitely on 30 October 2020, that CTO must be reviewed under section 76 of the Act, within 14 days before 30 October 2023. If the CTO had been extended indefinitely on 23 January 2020, it must be reviewed within 14 days before 23 January 2024. The intention is to stagger the CTO reviews throughout the first year after this part commences. This avoids the situation of all existing indefinite CTOs expiring at the same time, which would create an unmanageable burden for practitioners, the courts, and Legal Aid services.

Therefore, before 29 October 2023, Mental Health services will be required to review all existing indefinite CTOs and start planning for the reviews. If following that section 76 review, the Responsible Clinician (RC) is of the opinion that the patient is not fit to be released from compulsory status, the RC will then be required to apply to the Family Court for extensions under the provisions of section 34A for new 12-month CTOs.

In addition, the Act will still allow indefinite treatment orders to be applied for up until commencement on 29 October 2023. Meaning that these orders will expire up to 29 October 2024 and will also require application for extensions 14 days prior to their expiry dates.

6.11.2 Mental Health Service Process for DAMHS

Step 1

Mental Health Service to review all indefinite CTOs recording day and month the order was extended indefinitely under section 34(4).

Step 2

RCs to review patients under section 76 within 14 days before the anniversary date of the extended CTO (section 34(4)).

Step 3

RC to apply to Family Court under section 34A(2) for a new 12-month CTO extension (if required).

7 Part 3: Advice and assistance

Part 3 of the Mental Health Act sets out the role of the DAO:

So far as practicable, duly authorised officers shall act as a ready point of contact for anyone in the community who has any worry or concern about any aspect of this Act, or about services available for those who are or may be suffering from mental disorder; and, at the request of anyone, they shall provide all such assistance, advice, and reassurance as may be appropriate in the circumstances. (Section 37)

7.1 The role of the duly authorised officer

A DAO is a health professional appointed by a DAMHS under section 93 of the Mental Health Act. DAOs must have appropriate training and experience to be responsive to and empathetic towards the mental health concerns of a person (and their family or whānau) as they are granted particular powers under the Act. A supported decision-making approach can begin with a person's interactions with a DAO.

A DAO is able to support a person with concerns about their own mental health, or about someone else who appears to be experiencing a mental health problem. They can also investigate the matter to the extent that they believe there are reasonable grounds that the person in question may be **suffering** from a mental disorder.

DAOs engage with individuals, families, whānau and clinicians, building trust and collaboration in Act processes and noting how that process is experienced. For this reason, it is important that DAOs can recognise and support an individual's specific cultural and linguistic identity, such as if someone identifies with tikanga and te reo Māori, or fa'a Samoa. This can also include respecting a person's gender identity by using their preferred name and pronoun.

The DAO provides: general information, advice and practical assistance as to how the Act operates; information about the services available; and help with arranging assessments, including, if required, directing Police to assist in taking a person to the place where the assessment will be held. DAOs should also ensure that people are aware of the services of district inspectors and how to access these. After providing this information, DAOs must facilitate, if a person requests it, a call to a district inspector.

Where there is an interpretation barrier, such as where the person's first language is not English, DAOs must comply with section 6 of the Act, which requires a court, tribunal or person who is administering the Act to ensure that a competent interpreter

is available to help the person. It is important that a proposed patient understands the information available to them and has someone available to explain anything that is unclear. Such practice incorporates the principles of supported decision-making.

A DAO coordinates with proposed patients, patients, their family, whānau or caregiver, responsible clinicians, DAMHS, Police and any other person who may be involved with the assessment and treatment of the patient or proposed patient. The role that DAOs perform is broad. DAOs largely focus on whether or not a person requires an order under the Act or assessing whether or not a patient requires admission to hospital because, while they were living in the community, their health has deteriorated. The following are some of the tasks that DAOs may be involved in.

- Section 38(3), arranging non-urgent examinations: DAOs either arrange or help someone to arrange an examination (section 8B), and an application for assessment under the Act (section 8A).
- Section 39, helping an inpatient or outpatient while they are on leave: DAOs can respond to anyone's request for advice and assistance about any aspect of the care, treatment or conduct of an inpatient or outpatient while they are on leave. The DAO assesses the request and liaises with the clinician if they believe there are reasonable grounds to consider the case further.
- Section 40, assistance in taking or returning a proposed patient or patient to place of assessment and treatment: DAOs have a duty to help take patients and proposed patients to a place for assessment and treatment, consistent with sections 9, 11, 13, 14A(3)(b), 14A(3)(c) and 76(1A).
- Sections 40(2)(b), 50(4), 51(3) and 53: A DAO takes reasonable steps to return a patient (or special patient) to hospital if they have been absent without leave, if a special patient has had leave cancelled or if the DAMHS directs a patient be temporarily returned to hospital.
- Section 41, requesting assistance from Police: A DAO can call on Police assistance if a person requires an urgent examination. If necessary, the Police may be able to enter the premises of that person (with a warrant) and detain them for up to six hours or for the time it takes to conduct an examination.

The above is a subset of the range of work and roles DAOs perform. For more guidance on the exercise of DAO powers, particularly in relation to the compulsory assessment process, see: Ministry of Health. 2022. *Guidelines for the Role and Function of Statutory Officers Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health. This can be accessed online on the Ministry of Health website.

8 Part 4:

Special patients

Please read the information in this part alongside *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services*.¹⁰⁸

Section 2 of the Act defines five main categories of special patient:

- a person found unfit to stand trial and made a special patient under section 24(2)(a) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CP(MIP) Act)
- a person who is acquitted on account of insanity and made a special patient under section 24(2)(a) of the CP(MIP) Act
- a person found guilty of a and both sentenced to a term of imprisonment and detained as a special patient under section 34(1)(a)(i) of the CP(MIP) Act
- a remand or sentenced prisoner who requires treatment for a mental disorder in a forensic facility under sections 45 or 46 of the Mental Health Act
- a person remanded for a court report, or waiting for a trial or sentencing, under section 23, 35, 38(2)(c) or 44(1) of the CP(MIP) Act or section 184T(3) of the Summary Proceedings Act 1957.

8.1 Right to treatment

Section 44 of the Mental Health Act specifies that special patients must be given the same care, treatment, training and occupation as they would be given if they were subject to a compulsory treatment order. This includes equal access to all of the rights detailed in Part 6, sections 64–75 of the Act.

8.2 Non-consensual treatment

A special patient (other than a special patient admitted under section 46 of the Mental Health Act or detained in hospital under an order under section 23(2)(b), 35(2)(b) or 38(2)(c) of the CP(MIP) Act) is 'required to accept such treatment for mental disorder as the responsible clinician shall direct' 'during the first month of the currency of the compulsory treatment order' (section 59(1) of the Mental Health Act). That requirement may continue after that time if a psychiatrist (who is not the responsible clinician) appointed by the Review Tribunal considers that the treatment is in the patient's interests (section 59(2)(b)).

¹⁰⁸ Ministry of Health. 2017. *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services*. Wellington: Ministry of Health.

In all other cases, a special patient must give their written informed consent to treatment (section 59(2)(a)). The exceptions are for emergency medical treatment if the patient is unable to consent, or if a prisoner is undergoing compulsory assessment and treatment as a special patient (see section 45(4) of the Mental Health Act). For a more detailed discussion of consent, see 10.1: 'Consensual and non-consensual treatment' below.

8.3 Special patients detained under section 46

Special patients detained under section 46 of the Mental Health Act may only be treated if they have given their informed consent, like any other person admitted informally to hospital (see the Code of Rights, Right 7(1)). The only exception is where the patient needs emergency medical treatment and is unable to consent.

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

Three short-term special patient orders can be made under the CP(MIP) Act.

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

In addition, it is possible to detain a defendant in a hospital or secure facility under section 169 of the Criminal Procedure Act 2011. Before making this order, the court must be satisfied, on receiving a medical certificate from two health assessors, that a person is mentally impaired and that the detention is in their best interests.

All of the special patients described above are subject to section 43(1) of the CP(MIP) Act. This provision declares that any medical treatment or procedure may only be given

to such patients with their consent. If consent is not forthcoming due to incapacity, the DAMHS may authorise any treatment 'immediately necessary' to prevent the serious mental or physical deterioration of the person, or serious suffering by the person, or the person causing harm to self or others (section 43(2)).

The intention of section 43 of the CP(MIP) Act is to prevent routine treatment without consent when a person's legal status has not yet been finally determined through the criminal justice system. This provision overrides the treatment provisions of the Mental Health Act. These CP(MIP) Act special patient orders are short term in nature – section 23 and 35 orders run for a maximum of 30 days, while section 38 orders may run for up to 14 days – but if a person is obviously mentally disordered and would benefit from compulsory treatment, a clinician does not need to wait for the entire assessment or inquiry period to end before reporting to the court. If a person shows signs of serious deterioration, suffering or danger during this time, compulsory treatment that is immediately necessary is justified under section 43(2) of the CP(MIP) Act.

As section 36 of the Mental Health Act states:

... if, at any time while a compulsory treatment order is in force in respect of any person, that person becomes subject to an order made by a court under section 38(2)(c) or section 44(1) of the [CP(MIP) Act], the compulsory treatment order shall be suspended during the currency of that other order.

If a person is detained in a hospital on remand under section 44(1) of the CP(MIP) Act while waiting for a hearing or trial, general provisions applying to the treatment of special patients apply (see 8.2: 'Non-consensual treatment' above and Chapter 10).

Despite the provisions in section 43 of the CP(MIP) Act, if a person is detained in a hospital under section 23, 35 or 38 it is permissible to begin the process for compulsory assessment and treatment under the Mental Health Act.¹⁰⁹ It is irrelevant that the person was first detained under the CP(MIP) Act.

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

¹⁰⁹ *KR v Capital and Coast DHB* HC Wellington CIV-2011-485-700 19 April 2011, at [24].

8.5 Treatment of prisoners transferred from prison

8.5.1 Section 45

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

8.5.2 Section 46

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

A patient treated under section 46 may withdraw their consent. If they do so, arrangements should be made to transfer the person back to prison as soon as practicable (section 47(4)). However, if a clinician believes that such a person may be mentally disordered, the clinician should make arrangements with the prison's superintendent for the person to come to the hospital with a view to making an application under section 45(2), unless the clinician has seen the person within the last three days (as required by section 8A(c)).

8.5.3 Treatment while in prison

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

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

Under section 47 of the Act, the Director of Mental Health can approve the transfer back to prison of a patient who has been detained under section 45 of the Act. Section 47 also allows the Director of Mental Health to direct a patient (under section 46) to be returned to prison.

Section 47(3) of the Act notes that the prison concerned must make arrangements for the patient to be returned within seven days after the date on which the direction to transfer is given. It is rare for patients to be detained longer than a day after approval is received, but in such cases, they may only be treated with informed consent (except in an emergency) and may be detained in hospital with the authorisation of the prison.

8.7 Leave from hospital

A special patient cannot go outside of a hospital mental health unit on leave without being granted leave by the Director of Mental Health or the Minister of Health (sections 50 and 52). Special patients are eligible to be granted leave once the criminal justice process relating to their detention has been finally determined (section 50(2)). Before making a decision for or against granting leave, a special patient's clinicians and the Director of Mental Health must carefully assess that patient's risk and balance this assessment with the therapeutic value of leave.

8.8 Safe Transport of Special Patients

The Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021 introduced a new section 53A to the current Mental Health Act. Full details can be found in the of the *Guidelines for the Safe Transport of Special Patients in the Care of Regional Forensic Mental Health Services*.

These guidelines should be read in conjunction with these new provisions for transport of special patients for the purposes of Part 4 of the Mental Health Act and for attendance at court or parole board hearings. These guidelines apply to all Regional Forensic Mental Health Services (RFMHS) and also to hospitals and other inpatient mental health services involved in the interim custody of a special patient (such as during court processes).

Occasions when these special patients may need to be transported from the RFMHS to another service include transfers to:

- general hospital or specialist clinics for health treatment
- court in relation to charges against the individual, or as a witness
- prison or Police custody where it is no longer necessary for a person to be treated by the RFMHS.

The Mental Health Act provides authority for the detention of special patients in hospital. It also states that every patient 'is entitled to medical treatment and other health care appropriate to his or her condition' (section 66). There are times when such treatment will need to be undertaken outside of a secure forensic mental health unit. Leave is often sought for special patients so that they can access health care.

The CP(MIP) Act provides for the transfer of people detained in a hospital or secure facility for assessment (section 38(2)(c)) to court, penal or police custody (section 42) for three purposes:

- hearing or trial of a charge against the person
- sentencing of the person
- an appeal against the conviction of the person or against a sentence or order imposed on the person.

Section 53A of the MH(CAT) Act provides for the transport of special patients. A special patient custodian, that is, the Chief Executive of the facility where the special patient is held, (this may be delegated to the DAMHS) may authorize in writing the transport of special patients by a government agency for the purposes explained above. The agreement must include a transport management plan that has been approved in writing by the Director of Mental Health.

8.8.1 Transport Management Plan

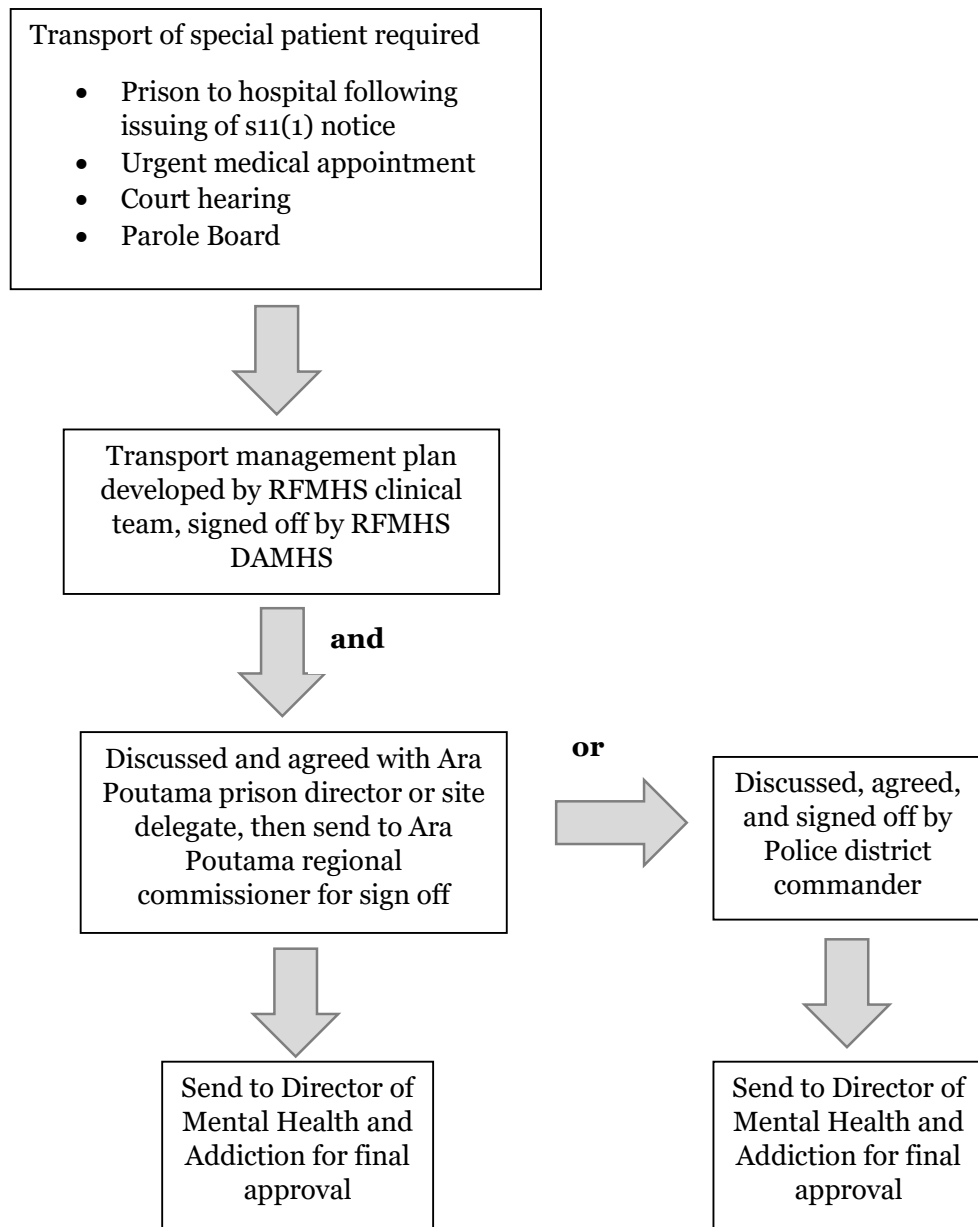
The transport management plan (transport plan) will specify the details of the transport of a special patient from a specific facility (prison or mental health service) to its destination (medical appointments or treatment at other hospitals, or for attendance at court or parole board hearings). The transport management plan may authorise:

- the use of restraint by the staff of the assisting agency if it is the least restrictive option for both the safety of the patient and the public
- the use of force that is reasonably necessary in the circumstances.

Transport plans will require an agreement between the RFMHS and Ara Poutama and need to be made on a case-by-case basis.

The RFMHS will approve the transport management plan and submit it to Ara Poutama for their approval. Subsequently, the Director of Mental Health will need to approve the plan in writing.

Summary of Process for Safe Transport of Special Patients



8.8.2 Use of Restraint

Section 53A of the MH(CAT) Act sets out the requirements for the use of restraint of a person during transportation. It is important to note that the use of restraint in these cases is not related to the presence of a mental health condition. Rather, it is related to offending or risk-taking behaviour, such as attempts to escape that pose a serious safety risk.

In addition, section 122B(2A) of the Mental Health Act states that the restraint of a person during transportation may be permitted only if it is reasonably necessary in the circumstances. In all situations where restraint is deemed as necessary, it must be clear that it is the least restrictive option available for both the safety of the patient and the public

Whether the use of restraint on a person is justifiable will depend on the circumstances of each individual case. In each case there must be an assessment of clinical and safety risks. Examination of alternatives to restraint and any use of restraint should be considered as a last resort where it is not safe to use alternative interventions or strategies.

Primarily, RFMHS should ensure that they have transport policies in place that actively minimise the use of restraint. Any further guidance about use of mechanical or physical restraint should be taken from police or Ara Poutama.

In order to minimise the risk to the patient, each RFMHS should have restraint guidelines in place that clearly identify:

- restraint approval process
- specific types of restraint that can be used
- processes to be used when considering restraint
- processes for reviewing the use of restraint on each occasion that it is used.

Restraint should only be used when recommended by the RFMHS, and in negotiation with Ara Poutama or other transport staff. Special patients who require Restraint must be observed by RFMHS staff at all times.

8.8.3 Documentation

When force is used while exercising a power under the Act, a mental health practitioner must complete a reportable event log recording the circumstances and forward it to the DAMHS as soon as practicable. A log for this purpose should comply with the RFMHS service provider reportable event policy and should include as a minimum:

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

8.9 Victim notification requirements for special patients and other forensic patients

On 13 December 2021 the Rights for Victims of Insane Offenders Act 2021 (Rights for Victims Act 2021) was passed by Parliament. This Act will come into force on 13 December 2022.

8.9.1 Current Provisions

Victims of specified offences committed by special patients and other forensic patients may apply to be notified of certain matters relating to the treatment of those patients, including first unescorted leave from hospital and change of legal status. For further guidance on victim notification requirements, see:

Ministry of Health. Victims' Rights Act 2002 Guidelines: For Directors of Area Mental Health Services, compulsory care coordinators and health victim coordinators. Wellington: Ministry of Health online.

N.B. The Victims' Rights Act Guidelines are being updated and the revised version is expected to be available online at the Ministry of Health by the end of 2022.

The Victims' Rights Act 2002 (VRA) confers certain notification rights on registered victims of offenders who are also special patients. Under section 37 of the VRA the delegate of the Director-General (usually the forensic DAMHS for special patients) must give reasonable prior notice to the victim of:

- the first unescorted leave of absence from the hospital
- the first unescorted overnight leave of absence
- an impending discharge.

In practice, 'reasonable prior notice' means using good judgement or being fair and practical about giving notice before the event occurs. In general, where the event is planned, notifications should be given 10 days in advance of that planned event.

Under section 37 of the VRA registered victims must also be told as soon as practicable if the special patient escapes or goes absent without leave (including failing to return from leave or dies).

The VRA specifies exceptions to section 37 once certain offenders are no longer liable to detention for the sentence imposed for the offence.

8.9.2 Additional provisions applying after 13 December 2022

As of 13 December 2022, reasonable prior notice must also be given to the victim of:

- the designation of a special patient or special care recipient if the offender is liable to be detained in a hospital or facility in connection with the offence as well as an explanation of the meaning and consequences of the person or offender's designation and a list of the future notifications that the victim is eligible to receive.
- leave granted under section 52 and 50 of the Mental Health Act
- an application received by the Mental Health Review Tribunal.

N.B. The Director (or delegate) may withhold advice of a particular condition of leave if in the Directors opinion disclosing the condition would unduly interfere with the privacy of any other person (other than the special patient).

For each notification, the Director of Mental Health (or their delegate) must take all reasonable steps to explain to the victim:

- the meaning and consequences of the person or offender's designation and a list of the future notifications that the victim is eligible to receive
- the process for granting a special patient leave of absence and how the victim may participate in that process
- the process for reviewing a special patient's condition by the Mental Health Review Tribunal and how the victim may participate in that process

As of 13 December 2022, Victims can make a submission to the Director of Mental Health regarding:

- leave decisions under section 50 and 52 of the Mental Health Act
- the review of a patient's condition by the Mental Health Review Tribunal.

As of 13 December 2022, the Director of Mental Health is required to have regard to any written submission made by a victim on the decision of whether to grant leave under section 50 or 52 of the Mental Health Act.

DAMHS should only share with victims the information about special patients which the VRA expressly requires.

Providing other information outside the scope of the VRA (eg the fact that a patient is being considered for ministerial long leave under section 50 of the MH(CAT) Act) may breach the Privacy Act 2020.

DAMHS or a responsible clinician can discuss with the special patient whether they consent for any additional information to be provided to the registered victim. DAMHS and responsible clinicians should consider any potential over-disclosure that may affect rehabilitation or reintegration of the special patient. Any such additional disclosures should only be made with the special patient's expressed consent.

Under section 50(F) of the Amendments to the Mental Health Act, information about victims must not be disclosed to the special patient, specifically the current address or contact details of any victim of the special patient.

9

Part 4: Restricted patients

Sections 54 to 56 of the Mental Health Act detail the process and effect of a restricted patient order.

Restricted patient status may be imposed on an inpatient who ‘presents special difficulties because of the danger he or she poses to others’ after the Director of Mental Health makes an application to the District Court. Such patients must be subject to an inpatient order. Restricted patients need not have entered the mental health services through the criminal justice system, but many such patients have a long history of contact with forensic services and may have previously been detained as special patients. A regional forensic psychiatry service manages restricted patients.

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

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

For further information on restricted patients, see: Ministry of Health. 2022. Sections 8 and 9, *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services*. Wellington: Ministry of Health.

10 Part 5: Compulsory treatment

Along with this chapter, please read the companion document to these guidelines, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*, which offers guidance to thinking about and applying a human rights approach and supported decision-making when implementing the Act.

10.1 Consensual and non-consensual treatment

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

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

A patient on a compulsory treatment order is 'required to accept such treatment for mental disorder as the responsible clinician shall direct' during the first month that the compulsory treatment order is current (section 59(1)).¹¹⁰ After the first month of an order, if a patient does not consent to treatment, compulsory treatment can still be given if a psychiatrist (other than the responsible clinician) appointed by the Review Tribunal considers that the treatment is in the patient's interests (section 59(2)(b)).¹¹¹

The use of compulsion does not remove the clinician's responsibility to obtain a patient's consent to treatment whenever possible. After the first month of compulsory treatment, in all cases except emergency treatment, a clinician must attempt to obtain a patient's written consent to treatment (section 59(2)(a)), which the patient may withdraw at any time (section 63).

¹¹⁰ An extension to a compulsory treatment order will not restart the requirement for a patient to accept treatment within the first month of an order under section 59(1) (see 6.11: 'Extension to compulsory treatment order').

¹¹¹ Except where the treatment involves electroconvulsive treatment or brain surgery.

10.1.1 Consent under the Mental Health Act¹¹²

'Consent' as used in section 59(2)(a) is not the same concept as 'informed consent' in the way clinicians generally understand it. A person gives their informed consent without coercion, whereas consent to compulsory treatment necessarily means some degree of coercion has already been used. In this case, the patient who is being asked to give their consent is already subject to a compulsory treatment order, and if they refuse consent that will not normally bring a compulsory treatment order to an end.

'Consent' in this context, therefore, refers to both informed consent and the lesser 'assent', which may be influenced by an element of coercion. For any consent to be valid, the patient must have the capacity to consent to the proposed treatment. Right 7(2) of the Code of Rights states, 'Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.'

The Medical Council of New Zealand describes informed consent as an interactive process between a doctor and patient to help the patient gain an understanding of their condition and make an informed decision about their care. This process includes having information about any expected risks, side effects, benefits and costs to the patient (if any) of each option.¹¹³ Clinicians seeking a patient's consent for treatment under the Mental Health Act should strive to meet the standard of **informed** consent to the greatest extent possible within the framework of the Act.

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

The RANZCP Code of Ethics recognises and describes the principles and practical guidance surrounding the task of seeking informed consent (see Principle 5). A patient will have capacity to consent if they are able to:

- understand the information relevant to the decision (see 11.4: 'Section 67: Right to be informed about treatment' below)
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate their decision (by any means).

¹¹² Suggested reading: Skipworth JJ. 2011. Capacity to consent to treatment in forensic mental health care. PhD thesis, University of Otago, Dunedin. URL: <http://hdl.handle.net/10523/1752> (accessed 29 July 2020).

¹¹³ Medical Council of New Zealand. 2019. Appendix 1: Information, choice of treatment and informed consent. URL: https://www.mcnz.org.nz/assets/MediaReleases/f74334fa3c/2019-Review_Appendix-1_Draft-informed-consent-statement.pdf (accessed 29 July 2020).

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

Assessment of decision-making capacity is recognised as a vital skill for clinicians, with important human rights implications.¹¹⁴ Capacity relates to the decision that must be made. For example, someone may have capacity to make a decision about one aspect of their health care, but not another. Decision-making capacity does not relate to whether a person is likely to make a 'good' choice; that is, people are entitled to make decisions that other people would consider unwise or foolish ('dignity of risk').

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

If a patient does not give written consent to treatment and no second opinion for treatment has been obtained, any treatment administered that is not covered under the provisions of urgent treatment (section 62; see 10.2: 'Non-consensual emergency treatment' below) is a breach of a patient's rights and may be considered an assault.

Clinicians are required to regularly and thoroughly discuss treatment options with patients who are on compulsory treatment orders (see 11.4: 'Section 67: Right to be informed about treatment' below). Compulsory treatment that relies on a second opinion should be a last resort. A second opinion will persist only for a reasonable period while a compulsory patient's mental state and treatment remain consistent within the scope of the opinion, and in any case will not continue for longer than one year.

10.1.2 Second opinions

If a patient does not consent to, or withdraws consent for, continued treatment after the first month under section 59(2)(a) of the Act, section 59(2)(b) requires that treatment can only continue if a psychiatrist (other than the responsible clinician), who has been appointed for this purpose by the Review Tribunal, determines that the treatment is in the interests of the patient. In other words, a second opinion is required.

¹¹⁴ Ryan C, Callaghan S, Peisah C. 2015. The capacity to refuse psychiatric treatment: a guide to the law for clinicians and tribunal members. *Australian & New Zealand Journal of Psychiatry* 49(4): 324–33.

Gaining consent from a patient applies to all proposed therapeutic interventions (that is, it is not limited to medication). This is also required to administer electroconvulsive treatment (ECT) when a patient does not consent under section 60 of the Act (a second opinion for ECT should be obtained outside the clinical team).

Second opinions are recognised as a way to improve the quality of mental health care, and to reduce the overall costs to individuals and society.¹¹⁵ Second opinions can help people learn more about their mental health condition, treatment and possible alternative treatments, and may provide them with some additional information to support their participation in treatment decisions.¹¹⁶

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

A psychiatrist providing a second opinion should:

- consider the patient's history, including the course of the illness and prior pharmaceutical regimes
- assess the relative risks and benefits of the range of potential treatment approaches
- consider the patient's views as far as they can be ascertained, by engaging with the patient; where reasonably possible, this may be accomplished through supported decision-making
- take into account any wishes or preferences the person has previously expressed and/or talk to family or whānau
- consider whether the treatment is the least restrictive alternative and proportionate to the assessed risks under the NZBORA
- seek to uphold the Code of Rights to the greatest extent possible
- consider whether the treatment is of greatest benefit to the patient and appropriate to the patient's condition (section 66 of the Act)
- consider whether the treatment is necessary to achieve the purpose of compulsory intervention.

Dawson et al¹¹⁷ suggest that the psychiatrist providing a second opinion 'should make an informed decision, based on the evidence, for which a reasonable justification can be given'. This will usually require study of the patient's files and communication with the responsible clinician (as well as possibly with other members of the treating team).

¹¹⁵ Heuss SC, Schwartz BJ, Schneeberger AR. 2018. Second opinions in psychiatry: a review. *Journal of Psychiatric Practice* 24(6): 434.

¹¹⁶ Second Psychiatric Opinion Service, Victoria, Australia. URL: <https://www.secondopinion.org.au/about-us/> (accessed 29 July 2020).

¹¹⁷ Dawson J, Ellis P, Glue P, Let al. 2013. Mandatory second opinions on compulsory treatment. In J Dawson, K Gledhill (eds) *New Zealand's Mental Health Act in Practice*. Wellington: Victoria University Press. pp 229–46.

The second-opinion psychiatrist should only endorse the current treatment if that treatment appears to be appropriate and/or efficacious. Opinions on best practice in relation to a certain patient's condition are likely to vary between clinicians, so it will be sufficient for second-opinion psychiatrists to implement good-practice treatment in line with the spirit of the Act and then, if appropriate, suggest alternatives that the responsible clinician must consider.

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

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

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

10.1.3 Recording of second-opinion processes

Sections 59 and 60 second opinions must be adequately recorded in the patient's files. At a minimum the information recorded should include:¹¹⁸

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

¹¹⁸ Dawson et al, 2013, above note 117.

10.2 Non-consensual emergency treatment

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

10.3 Electroconvulsive treatment

The special provisions relating to electroconvulsive treatment are contained in section 60 of the Act. The Act requires two procedures to be followed before ECT may be administered:

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

Whenever considering ECT, clinicians should take into account the RANZCP publication ‘Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy’.¹¹⁹

For more information for consumers and their families, see: Ministry of Health. 2009. *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know*. Wellington: Ministry of Health.

10.3.1 Electroconvulsive treatment with consent

The Act expects a patient needs to give their consent before ECT can be administered (section 60(a)). The responsible clinician should always attempt to gain a patient’s agreement to ECT by fully explaining the expected benefits and side effects in line with section 67 (see 11.4: ‘Section 67: Right to be informed about treatment’ below). Rights 5 and 6 of the Code of Rights – the rights to effective communication and to be fully informed – reinforce this expectation.

As with any power exercised under the Act in respect of a person, section 5 applies where clinicians are considering ECT as part of the person’s treatment. That is, they must give proper respect to the person’s cultural identity and personal beliefs. This may involve, for example, working collaboratively with kaupapa Māori mental health

¹¹⁹ Weiss A, Hussain S, Ng B, et al. 2019. Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy. *Australian & New Zealand Journal of Psychiatry* 53(7): 609–23. DOI: 10.1177/0004867419839139 (accessed 30 July 2020).

services and family or whānau to navigate whether ECT is an appropriate option, because a person's head is considered tapu (sacred) within tikanga Māori.

For any consent to be valid, the consenting patient must have the capacity to consent to ECT (see 10.1: 'Consensual and non-consensual treatment' above). The RANZCP notes the following in relation to seeking informed consent from patients considering ECT.

- Clinicians should provide enough information for patients to make an informed decision. RANZCP recommends involving families, whānau and caregivers in this process where possible. Clinicians should allow adequate time for patients and their families, whānau and caregivers to discuss any concerns.
- During the consent process, clinicians should give patients information on the potential side effects of ECT, particularly the possible loss of short-term and recent memories around the time of ECT and, occasionally, past memories. They should take into account the patient's mental state in deciding on the level of detail to give them.¹²⁰

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

Because mental illness can affect capacity, it is desirable for compulsory patients to express views about the acceptability of possible future treatment options, including ECT, at a time when they have capacity to consider those options. If patients record competently expressed views on ECT and later lose their capacity to consent, responsible clinicians and psychiatrists providing second opinions under section 60 of the Act must consider those earlier views. Section 5 of the Act requires clinicians to exercise powers the Act gives them with proper respect for the person's cultural identity and personal beliefs.

10.3.2 Electroconvulsive treatment with second opinion

Where a patient is either not competent to consent or refuses to consent, ECT can be administered if a second psychiatrist, who has been approved by the Review Tribunal and practises independently of the requesting clinical team, considers the treatment to be in the interests of the patient (section 60(b)). Although this provision potentially allows a patient's competent refusal to be overridden by what is considered to be in the interests of the patient, good clinical practice will dictate that this only occurs in exceptional circumstances.¹²¹

The Ministry recommends that a second opinion should apply to only one course of ECT treatments at a time. Clinicians should attempt to obtain consent for each new

¹²⁰ RANZCP. 2014. Electroconvulsive therapy (ECT): Position statement 74. URL: [https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/electroconvulsive-therapy-\(ect\)](https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/electroconvulsive-therapy-(ect)) (accessed 30 July 2020).

¹²¹ See Principle 5 of RANZCP. 2018. *Code of Ethics*. Melbourne: Royal Australian and New Zealand College of Psychiatrists.

course of treatment. For an acute treatment course, we recommend reviewing and renewing consent after approximately 12 treatments. For maintenance (continuation) ECT, we recommend that patients renew their written consent at regular intervals, such as every six months or after every 12 treatments.

For further information about ECT in a New Zealand context, see: Ministry of Health. 2004. *Use of Electroconvulsive Therapy (ECT) in New Zealand: A review of efficacy, safety, and regulatory controls*. Wellington: Ministry of Health. URL: <https://www.health.govt.nz/publication/electroconvulsive-therapy-ect> (accessed 30 July 2020).

11 Part 6: Rights of patients and proposed patients

Sections 64 to 75 of the Act set out the rights of patients who are subject to the Act. Proposed patients have the same rights as patients (see 11.12: 'Rights of proposed patients' below), except the right to receive and send letters and postal articles (sections 73 and 74 of the Act) given that proposed patients spend only a short time in the assessment (usually a few hours).

The rights in sections 64 to 75 of the Act supplement the rights that the NZBORA affirms and the rights that all health service consumers (including patients and proposed patients under the Act) enjoy under the Code of Rights. The powers for providing compulsory assessment and treatment under the Act should be read consistently with the rights in the NZBORA and the Code of Rights as far as possible.

Rights of patients and proposed patients specified under the Act put an obligation on the health and disability system to:

- provide equitable patient care
- give patients and proposed patients access to comprehensible information
- obtain informed consent
- ensure patients and proposed patients have company and communication with others
- ensure patients and proposed patients are able to make complaints regardless of their demographic characteristics (including sex, ethnicity, religion and language).

Health systems have the means to continually work towards a positive culture for patients, their families and whānau, and staff. The current set of rights under this Act has potential to enhance a person's quality of life while they are receiving compulsory assessment and treatment. Upholding rights potentially can also promote positive health environments. It is important to remember that the rights of patients and proposed patients under the Act are enforceable through the complaints mechanism under section 75 of the Act.

Along with this chapter, please read the companion document to these guidelines, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*, which offers guidance to thinking about and applying a human rights approach and supported decision-making in the context of implementing the Act.

11.1 Section 64: General rights to information

In addition to receiving information about proposed treatment (see 11.4: 'Section 67: Right to be informed about treatment'), at the time of becoming a patient (section 64(1)) patients must be given a written statement of their rights as a patient under the Act and must be kept informed of their changing status and review and appeal rights (section 64(2)). Note that section 23(1)(a) of the NZBORA states, 'Everyone ... who is detained under any enactment ... shall be informed at the time of the ... detention of the reason for it'. This right to information extends to proposed patients.

For the current plain-English translation of rights that patients and proposed patients have under the Act, go to: Ministry of Health. 2020. Your rights under the Mental Health (Compulsory Assessment and Treatment) Act 1992. URL: <https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health-compulsory-assessment-and-treatment-act-1992/your-rights-under-mental-health-compulsory-assessment-and-treatment-act-1992> (accessed 30 July 2020).

A person may become 'detained' for the purposes of section 23(1) of the NZBORA before becoming a proposed patient if the situation is urgent and the Mental Health Act's section 38 procedures are adopted.¹²² If the person is urgently detained under section 38, the DAO should if possible, inform the person of the reason for their detention, their right to consult a lawyer and their right to have a court decide on the validity of their detention. The DAO may give this information by providing a written statement of those rights. It is good practice for district mental health services to include a detained person's rights under section 23(1) of the NZBORA in the statement of rights that they must supply under section 64(1) of the Mental Health Act.

If a patient is not included in a meeting with the clinical team and their family or whānau, the patient should receive feedback after the meeting about the participants discussed. We recommend that clinical teams also provide contact details for the Nationwide Health and Disability Advocacy Service. Advocates can help consumers resolve their concerns about any aspect of their care and treatment and can complement the services that district inspectors provide.

General rights to information should include, for example, information about the process for deciding on leave from the Act and for cancelling leave in writing. This is a very important matter for detained patients.

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

¹²² *Sestan v DAMHS*, above note 90.

11.2 Section 65: Respect for cultural identity

Section 65 of the Act affirms that 'Every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5'.

Right 1(3) of the Code of Rights reinforces this requirement. It states, 'Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori'.

Section 15 of the NZBORA states, 'Every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private'.

The right to be dealt with in a culturally appropriate manner is enforceable through the complaints procedures set out in section 75 of the Mental Health Act. In addition, the Health and Disability Commissioner can investigate an alleged breach of Right 1(3).

Respect for cultural identity includes enabling a patient to communicate in their language of choice, wherever practicable, and respecting cultural concepts such as those related to the body or to the appropriateness of interactions with male or female staff. Note that mental health and addictions services should make interpreters available for all patients where possible. See 4.2: 'Section 6: Use of interpreters' above for more information about interpreters and communicating with proposed patients and patients who have a first language other than English. See Chapter 4 more generally for more in-depth discussion about culturally safe care.

Le Va offers a national programme, Engaging Pasifika Cultural Competency, which provides health professionals with the opportunity to learn skills and knowledge to effectively engage Pacific patients and their family.¹²³

Additionally, the Medical Council of New Zealand has developed key documents, statements, frameworks and other resources that offer specific methods and tools to incorporate cultural competency within the health system.¹²⁴

¹²³ <https://www.leva.co.nz/news/an-organisational-approach-to-cultural-competency>

¹²⁴ <https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/>

11.3 Section 66: Right to treatment

Under section 66, 'Every patient is entitled to medical treatment and health care appropriate to [their] condition.' Treatment should be holistic and seek to address the range of factors that impact on a person's condition (for example trauma, substance use, cultural factors or chronic pain).

The Mental Health Act takes an ethnocentric view of treatment, primarily presuming a biomedical model of care. We encourage services and clinicians to investigate and incorporate non-biomedical treatment that can further benefit patient recovery and wellbeing, depending on their preferences, cultural identity and personal beliefs.

Incorporating non-Western and non-biomedical therapies requires multidisciplinary care, which is consistent with the recovery approach to mental health. The Ministry of Health supports a recovery approach to mental health, which can be interpreted as supporting a person to live a self-directed life and minimising the impact of potential stressors. Suggestions for additional health care may include, but are not limited to, psychological therapies, *tohunga* (in all healing practices), *mirimiri*, *rongoā Māori*, *maara kai*, occupational therapy, meditation, acupuncture, *tai chi*, and yoga.

Moreover, if the person has a compulsory inpatient treatment order, they have the right to be offered the same level of treatment and care that would be available to any other hospital patient for health conditions not related to the mental disorder. Recognising this right may involve helping the person to access treatment in areas such as dentistry, hearing aids and glasses. Staff should be alert to the need for prompt treatment where patients are complaining of pain, for example, dental pain and arthritis.

11.4 Section 67: Right to be informed about treatment

Before starting any treatment, patients have the right to receive 'an explanation of the expected effects of any treatment ... including the expected benefits and the likely side effects' (section 67). This right supplements the general right of all health service consumers to receive all the information about treatment options and risks that any reasonable person, in the same circumstances, would expect to receive (Rights 6(1) and 6(2), Code of Rights).

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

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

The right to be informed is an important part of the consent process as 10.1: 'Consensual and non-consensual treatment' describes above. Poor information will not allow the patient to make an informed decision and may lead to judicial review.¹²⁵

Patients have a right to effective communication in a form, language and manner that enables them to understand the information provided, and in an environment that enables open, honest and effective communication (Right 5, Code of Rights). Clinicians should always consider the patient's present mental state, and should repeat information as appropriate if that state alters. Where they communicate in written form, they should also explain the same information verbally. Under Right 6(4) of the Code of Rights, 'Every consumer has the right to receive, on request, a written summary of information provided'.

Patients and their families and whānau need time with members of the treatment team to fully understand all possible treatment options (not just medication) and the potential side effects. This includes having the time to discuss plans such as advance directives to be used at those times when a person is too acutely ill to consent to treatment.

Clinical teams should inform patients and their families and whānau that district inspectors are available to support them in their understanding of the legal rights and obligations available under the Act.

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

Section 68(1) of the Act states that every patient has the right to be informed of any intention to make or use a videotape or other visual or audio recording of any interview with, or any other part of the treatment of, the patient. Section 68(2) requires the prior consent of the patient or their personal representative for any such recording.

¹²⁵ *JE v Capital and Coast DHB* HC Wellington CIV-2009-485-1106, 19 June 2009.

Using closed-circuit television (CCTV) to record patient activities and treatment in an inpatient unit can only be done with the consent of all patients in that unit. The one exception is that CCTV may be used for the security of people entering and exiting the unit (that is, facing the entry and exit doors to the unit).

Note that under rule 4 of the Health Information Privacy Code 2020, a health agency must not collect health information by unlawful means or by means that are unfair or that intrude to an unreasonable extent on the personal affairs of the individual concerned. Visual or audio recording of a patient contrary to section 68 of the Act would likely also be contrary to rule 4 and may entitle the patient to complain under the Privacy Act 2020.

11.6 Section 69: Right to independent psychiatric advice

The DAMHS appoints the personnel who undertake the statutory assessment procedures. If a person exercises their right to independent psychiatric advice, an additional process is involved that will usually occur only in a non-urgent situation.

‘Independent’ means independent of the process of treating the patient. It does not mean that a psychiatrist who is employed by another service will necessarily be provided. However, section 69 states that the patient is entitled to seek consultation with ‘a psychiatrist of [their] own choice’. On that basis, if the patient chooses a particular psychiatrist from another service, the staff responsible for the patient’s care and treatment should facilitate the consultation with that psychiatrist. The patient is responsible for paying any costs of getting advice from psychiatrists not employed by the district mental health service that is treating the patient.

11.7 Section 70: Right to legal advice

Services should ensure that patients and their families and whānau are aware of, or have the contact details of, district inspectors available in their area. Ideally, acute wards will display the names and contact details of district inspectors prominently.

To allow for access to alternative legal advice, services should make satisfactory arrangements with the local branch of the New Zealand Law Society so that a patient or proposed patient can get the services of a lawyer if they do not already have a lawyer. One way of facilitating this access is for services to obtain from the Law Society a list of names of counsel with suitable experience and training to give legal advice under section 70 of the Act.

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

11.8 Section 71: Right to company, and seclusion

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

Since the creation of the Mental Health Act, attitudes to the use of restrictive practices have evolved. The goal of reducing and eventually eliminating seclusion in mental health services was introduced in 2012.¹²⁶ It is now generally recognised that seclusion has no therapeutic value. More than that, research shows that seclusion and restraint can actually damage relationships and traumatise both the person and staff involved.¹²⁷ Our data tells us that nationally Māori and Pacific peoples are much more likely to be secluded than others.¹²⁸ Addressing this inequity requires inpatient services to emphasise reducing seclusion rates for Māori and Pacific peoples and is linked to providing culturally responsive services (see Chapter 4).

In rare cases, staff may decide that seclusion is necessary to ensure the safety of the patient or the safety of others. In such cases, they should comply with:

- section 71 of the Act
- the procedures set out in the Ministry's *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*¹²⁹
- the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008).¹³⁰

¹²⁶ Ministry of Health. 2012. *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. Wellington: Ministry of Health.

¹²⁷ Te Pou o te Whakaaro Nui. 2014. *Debriefing following seclusion and restraint: A summary of relevant literature*. URL: <https://www.tepou.co.nz/uploads/files/resource-assets/debriefing-following-seclusion-and-restraint-281014.pdf> (accessed 24 July 2020).

¹²⁸ Ministry of Health, 2019, above note 6.

¹²⁹ Ministry of Health. 2010. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

¹³⁰ Following sector consultation in 2017, Standards New Zealand and the Ministry of Health are currently reviewing the Health and Disability Services Standards.

In such circumstances, clinicians should also assess a proposed patient as a matter of urgency. No more force than is necessary should be used to seclude a person.¹³¹

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

This section applies to patients and proposed patients equally. In some cases, a proposed patient may wish to advise others of their compulsory assessment under the Act and to make personal arrangements. If it is safe to do so, staff should give the proposed patient access to a telephone.

Depending on the nature of the inpatient unit and potential risks, it may be appropriate to monitor and, if necessary, restrict a person's access to their personal mobile phone (see 11.13.1: 'Unreasonable search and seizure' below). However, another consideration should be that removing a person's mobile phone may also remove access to a range of digital forms of communication such as email, social media platforms and the internet, which has an impact on rights under sections 73 and 74 as discussed below. It is important to exercise some flexibility in this decision and it is the responsible clinician who needs to be making a clinical judgement about whether to take phones away from a patient. Additionally, it would be sensible to expect a regular review of any such clinical decision, in order to evaluate whether the restriction continues to be appropriate.

Further, clinicians should consider patient access to video calls or conferencing options. Such access might be particularly relevant if it facilitates the family or whānau consultation required under section 7A of the Act, or enables a patient to achieve and maintain connections with family or whānau as part of their cultural, ethnic, language or religious identity, in line with sections 5 and 65 of the Act.

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

Sections 123 and 124 of the Act limit the rights under sections 73 and 74 to send and receive letters and postal articles when a person is undergoing compulsory assessment or inpatient treatment in a hospital. The responsible clinician may withhold correspondence that is not in the interests of the patient to send or receive, unless the correspondence is to or from an official or legal or medical professional as specified in

¹³¹ Suggested reading: Health Quality & Safety Commission. 2018. *Reducing and Eliminating Seclusion in Mental Health Inpatient Services*. Wellington: Health Quality & Safety Commission.

section 123(3) of the Act. If a person has notified a hospital that they do not wish to receive communications from a patient, such correspondence may be withheld. These sections do not apply to proposed patients because of the short duration of the assessment period.

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

Withheld correspondence must be presented to a district inspector under section 125.

11.11 Section 75: Complaint about a breach of rights

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

Section 97 allows district inspectors and official visitors to have access to every part of the hospital or service and to every person in it, whether detained or not. Where required, services must present district inspectors and official visitors with all registers and records required to be kept by or under this Act, and such orders and other documents relating to any of the patients. Withholding requested information may be considered obstruction and such barriers are grounds for an inquiry under section 95 of the Act.

All consumers of health and disability services may make complaints to the Health and Disability Commissioner about breaches of rights affirmed in the Code of Rights. Independent advocates through the Nationwide Health and Disability Advocacy Service are available to support and guide consumers on ways to resolve their concerns about a breach of their rights, or consumers can make a complaint directly to the Health and Disability Commissioner. For further information, go to the Health and Disability Commissioner's website www.hdc.org.nz.

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

For further information, see: Ministry of Health. 2012. *Guidelines for the Role and Function of District Inspectors: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

11.12 Rights of proposed patients

Section 2A of the Act defines 'proposed patient', while section 63A (in addition to the Code of Rights) describes the rights of proposed patients. A person becomes a proposed patient when an application is 'made' under section 8A of the Act. An application is 'made' when the DAMHS receives both the completed application form under section 8A of the Act and the certificate issued under section 8B of the Act. The rights of proposed patients under section 63A do not apply during the assessment of the person by the mental health practitioner, nurse practitioner or registered nurse working in mental health under section 8B, or during the applicant's contact with the person.

Proposed patient status ends when a mental health practitioner either:

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

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

11.13 Rights under the New Zealand Bill of Rights Act 1990

Many rights under the NZBORA are relevant to the compulsory assessment and treatment process. Mental health service staff should take the NZBORA into account when making decisions under the Mental Health Act. The relationship between the NZBORA and the Mental Health Act means those applying the Mental Health Act must use the least restrictive approach possible.

Along with this section, please read the companion document to these guidelines, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. It offers guidance to thinking about and applying a human rights approach and supported decision-making in the context of implementing the Act.

11.13.1 Unreasonable search and seizure

Mental health services have a duty of care to provide safe and appropriate services of a reasonable standard,¹³² to protect vulnerable consumers in their care from injury¹³³ and to take all practicable steps to ensure the safety of their employees.¹³⁴ Normally, a power to search a person and/or seize their property must be specified in statute. No such power is specified in the Mental Health Act, but the Ministry considers that such a power is necessarily implied for the effective and safe provision of compulsory mental health care.

Section 21 of the NZBORA requires that a search and seizure policy is reasonable, and that each particular act of searching for or seizing property must also be reasonable. To comply with section 21, inpatient units should develop search and seizure policies providing for reasonable searches that:

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

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

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

Rational processes for search and seizure should always include:

- having appropriately experienced and trained staff to carry out searches and seizures
- keeping adequate records, including making a list of the items removed and giving a copy of the list to the owner of the property
- retaining property for only as long as necessary to achieve the purpose for which it was removed
- having management review instances of search and seizure
- appropriately storing or disposing of property.

¹³² See Right 4 of the Code of Rights; section 66 of the Mental Health Act.

¹³³ Section 151 of the Crimes Act 1961.

¹³⁴ Section 3 of the Health and Safety at Work Act 2015; section 22(1)(k) of the New Zealand Public Health and Disability Act 2000.

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

In some situations, the law explicitly permits a search. For example, a personal search may be reasonable in the following situations.

- A senior clinician has reason to believe that an inpatient is in possession of controlled drugs. The clinician may ask the person to voluntarily hand over any controlled drugs, and a search may be carried out under a policy developed in line with the principles described above. However, if an intrusive or internal search becomes necessary, the clinician should not perform the search but may refer the matter to a member of the Police to do so (see the Search and Surveillance Act 2012, Subpart 7 – Police powers in relation to Misuse of Drugs Act 1975 offences).
- Someone has reason to believe that a person is in the possession of a weapon or dangerous substance that the person is going to use to attempt suicide or to commit an offence that could cause immediate and serious injury to any person or property. In such cases, characterised by extreme urgency and serious consequences, a personal search may be justified under section 41 of the Crimes Act 1961.

11.13.2 Proper process for detention under the Act

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

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

11.13.3 Right to refuse medical treatment

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

Section 23(5) of the NZBORA provides that everyone deprived of their liberty (including under the Mental Health Act) must be treated with humanity and with respect for the inherent dignity of the person.

12 Part 7: Reviews and judicial enquiries

The clinical and judicial review process differs depending on the nature of a patient's treatment order. Figures 4 to 7 at the end of this chapter outline the review process for different types of treatment orders.

12.1 Duty to conduct clinical review of patients

The responsible clinician must formally review all compulsory patients under section 76, 77 or 78 of the Act, with the particular section depending on the type of order the patient is subject to. The first clinical review must occur within the first three months of the court order allowing compulsory treatment.¹³⁵ Subsequent clinical reviews must occur within six months of the previous review. The duty to review a patient's condition regularly does not end when a compulsory treatment order is of indefinite duration.

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

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

The clinical review should be a rigorous, holistic assessment of the person's condition, which considers the range of factors relevant to a person's condition (for example, family and whānau, substance use/addiction, least restrictive options). We expected that it will include family or whānau consultation as well.

¹³⁵ It is not necessary to perform a clinical review within the first three months of an extended compulsory treatment order (see 6.11: 'Extension to compulsory treatment order').

12.2 Applications to the Mental Health Review Tribunal

After a certificate of clinical review has been completed, any person to whom the certificate was sent may apply to the Review Tribunal for a review of the patient's condition. An application can be facilitated through a district inspector. In all cases, permitted applicants to the Review Tribunal under section 76(7)(b) will include:

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

If a clinical review has been carried out on a special patient acquitted on account of insanity, or unfit to stand trial, the Director of Mental Health may also apply to the Review Tribunal (section 77(3)(b)(ii) and (4)(b)(ii)). Another situation in which the Director of Mental Health may apply to the Review Tribunal is where a clinical review recommends release from compulsory status for a restricted patient (section 78(5)(b)). The Attorney-General and Minister of Health may refer cases to the Review Tribunal as well in certain situations under sections 77 and 78.

In addition, the Review Tribunal may review a patient's condition on its own motion (section 79(2)). Regardless of whether a patient has received a certificate for clinical review, they are free to communicate with the Convenor of the Review Tribunal and request a review. The Review Tribunal is under no obligation to act on such a request.

12.3 Mental Health Review Tribunal reviews of patients

Following a clinical review, any person who has received a copy of the certificate of review may apply to the Mental Health Review Tribunal under section 79, 80 or 81 of the Act, with the section depending on the type of order the patient is subject to. The Mental Health Review Tribunal's statutory procedure is set out in Schedule 1 to the Act.

A number of Mental Health Review Tribunal decisions are anonymised and provided to the New Zealand Legal Information Institute, a publicly accessible online database of legal resources.¹³⁶ These decisions may help future applicants to the Mental Health Review Tribunal.

¹³⁶ New Zealand Legal Information Institute. Database: New Zealand Mental Health Review Tribunal. URL: www.nzlii.org/nz/cases/NZMHRT/ (accessed 31 July 2020).

12.3.1 Functions of the Review Tribunal

The four principal functions of the Mental Health Review Tribunal are to:

- review the condition of patients, special patients and restricted patients (under sections 79 to 81 of the Act)
- investigate complaints of breaches of specific patient rights where a patient or complainant is not satisfied with the outcome of the investigation of a complaint by a district inspector or an official visitor (under section 75 of the Act)
- appoint psychiatrists for the purposes of sections 59, 60 and 61 of the Act
- report to the Director of Mental Health on any matter relating to the exercise or performance of its powers and functions (section 102 of the Act).

12.3.2 Arranging a review

Under section 79(5) and (6) of the Act, reviews must begin within 21 days of the Review Tribunal receiving the application. The Review Tribunal can extend that time by no more than seven days. This means health professionals, lawyers and others involved in a review need to act swiftly as soon as they become aware of an application.

To facilitate a timely and informed review, the Review Tribunal (usually through its secretariat):

- issues a notice of application for review and procedure for hearing shortly after it receives an application
- convenes a telephone conference to identify and consider pre-hearing issues, in which participants are the responsible clinician (or, in their absence, a suitably informed clinician or the DAMHS), the patient or their lawyer, and a member of the Review Tribunal
- gives notice of the review date. The Review Tribunal aims to set convenient dates but that is not always possible given that the Review Tribunal members usually fly in from elsewhere and the patient, lawyers and health professionals sometimes have conflicting commitments.

12.3.3 Hearing location and attendees

The Review Tribunal usually hears applications at a district mental health service or community facility near where the patient lives, unless it directs otherwise. It is the responsibility of the district mental health service and DAMHS to make appropriate facilities available. These facilities include:

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

People who usually attend hearings are:

- the patient and their lawyer and support person (if any)
- family or whānau members who the patient has asked to attend

- the responsible clinician
- a second health professional.

Other people may attend, as of right in some cases (for example, a district inspector) and at the discretion of the Review Tribunal in some other cases. If a responsible clinician considers that it would be helpful for other people to attend, then they should advise the Review Tribunal of that at an early stage.

12.3.4 Health professional reports to the Mental Health Review Tribunal

Good-quality evidence and good-quality reports from health professionals are essential to enable the Mental Health Review Tribunal to discharge its function. Reports need to fully address the statutory criteria and assist the Review Tribunal to meet its obligation under section 5 of the Act to exercise its powers and conduct proceedings **with proper respect for the patient's cultural identity and personal beliefs.**

Health professionals also need to provide their reports in a timely way so that the patient and lawyer can prepare and the Review Tribunal can understand the issues in advance of the hearing. Timely reporting may resolve the issues that led to a review. A minimum of seven days before a hearing:

- the responsible clinician provides a substantive report to the Review Tribunal, which will properly inform the Review Tribunal of all relevant aspects of the patient and their care. To help responsible clinicians with this task, the Review Tribunal has issued 'Guidelines for reports to the Review Tribunal by responsible clinicians'¹³⁷
- a second health professional provides a brief report to the Review Tribunal, often in the form used for compulsory treatment order hearings.

12.3.5 Reports related to special patient and restricted patient status

When reviewing special patients and restricted patients, the Mental Health Review Tribunal usually needs a copy of the decisions of the court imposing that status. It requires this because the decisions:

- are the foundation for that status
- contain the grounds for imposing that status
- are a record of the relevant facts and circumstances
- may help in identifying relevant risks and patterns.

DAMHS and responsible clinicians are likely to have received these court reports, and they are encouraged to share such information with the Mental Health Review Tribunal

¹³⁷ Mental Health Review Tribunal. 2018. Guidelines for reports to the Review Tribunal by responsible clinicians. Wellington: Mental Health Review Tribunal. URL: <https://www.health.govt.nz/system/files/documents/pages/mhrt-clinical-report-writing-guidelines-apr2018.pdf> (accessed 31 July 2020).

and supply copies. Where DAMHS or responsible clinicians have not received certain court reports, the Review Tribunal may seek these documents from the Ministry of Justice.

12.3.6 The review hearing process

Schedule 1 of the Act contains procedural provisions relating to review hearings, which include some of the powers of the Review Tribunal and the rights of the patient and others involved. The Schedule allows for a very formal review process, but the Review Tribunal has broad power to determine its own procedure and tries to reflect a more informal process. It conducts proceedings:

- (a) with proper recognition of the importance and significance to the patient of ties with [their] family, whānau, hapū, iwi, and family group, and
- (b) with proper recognition of the contribution those ties make to the patient's wellbeing, and
- (c) with proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs (section 5(2)).

As part of conducting proceedings in this way, the Mental Health Review Tribunal may co-opt members of the same ethnicity as the patient and also have an interpreter present.

The Ministry of Health website contains practice notes and guidelines from the Review Tribunal.¹³⁸ The Review Tribunal updates these from time to time.

12.3.7 The powers of the Mental Health Review Tribunal

The Mental Health Review Tribunal is an independent statutory body. It aims to operate with the common-sense cooperation of those involved in administering and applying the Act. However, it has significant powers, which mirror many powers of a court and a commission of inquiry. In particular, it has:

- express powers under the Act, to enable it to perform its functions
- many of the powers available to a commission of inquiry, which section 104(3) of the Act confers
- inherent powers to regulate its own procedure, to ensure fairness and to prevent an abuse of process.

In particular, its powers include the power to:

- require parties to produce evidence and other material, in a form that it specifies
- summons and call witnesses
- require people to give evidence on oath

¹³⁸ <https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/mental-health-review-tribunal/mental-health-review-tribunal-resources>

- determine the extent of evidence to be put before it
- excuse the attendance of the patient, on limited grounds
- permit people other than those specified in the Act to be present during a hearing, and require witnesses to withdraw from the hearing (Schedule 1, clause 7 of the Act)
- grant leave to publish reports of the proceedings (including its decisions)
- call for an independent report on the patient. If the Review Tribunal does so, it must order that a party to the proceeding or a Parliamentary appropriation meets the costs (Schedule 1, clause 5 and clause 6(5) of the Act).

The Review Tribunal exercises some of its powers through its secretariat. This usually occurs at the pre-hearing stage, for example when sending out notices, seeking reports and setting telephone conference and hearing dates. It may also occur after the hearing when the Review Tribunal is seeking further material or issuing decisions.

Support for the Review Tribunal's powers comes from offence provisions and the ability for the Review Tribunal to report matters of concern to the Director of Mental Health.

12.3.8 Making recommendations and referring matters to a district inspector, the Director of Area Mental Health Services and Director of Mental Health

From time to time, the Review Tribunal may make recommendations or observations. Usually its focus is on the care and treatment to offer the patient and general procedural and evidential issues.

It may draw matters of concern to the attention of a district inspector, the Director of Area Mental Health Services or the Director of Mental Health. When required, or of its own motion, under section 102 of the Act it may make a report to the Director of Mental Health on any matter relating to the exercise of its powers and functions under the Act.

12.4 Appeal against Mental Health Review Tribunal decision

After the Mental Health Review Tribunal has reviewed a patient under a compulsory treatment order and found that the patient remains mentally disordered, any of the following people may appeal that decision to the court:

- Director of Mental Health
- Director of Area Mental Health Services
- the patient

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

An appeal follows the same process as an application for review under section 16 (see 5.7: 'Section 16: Review by a judge' above).

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

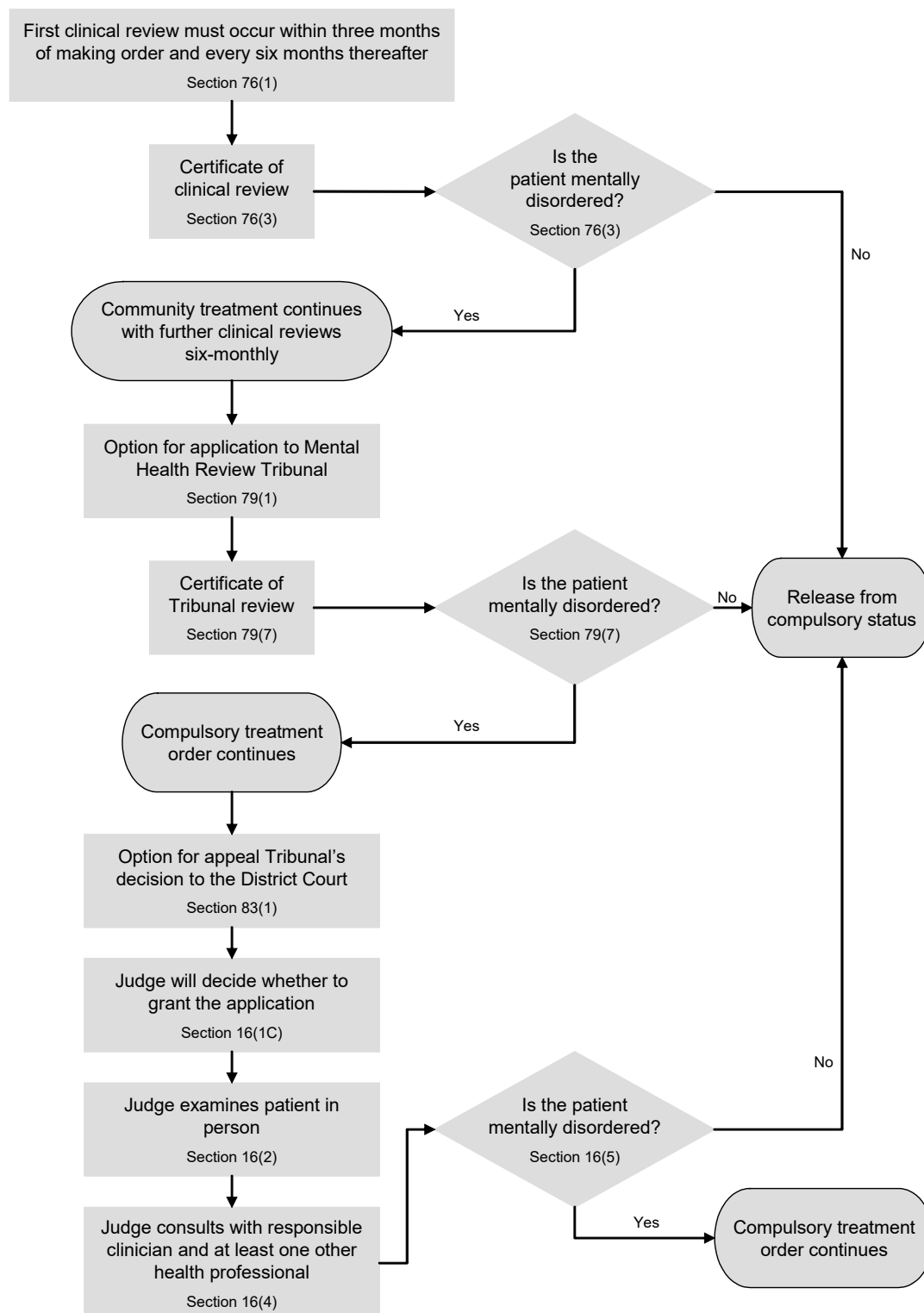


Figure 4: Clinical and judicial review of special patients acquitted by reason of insanity

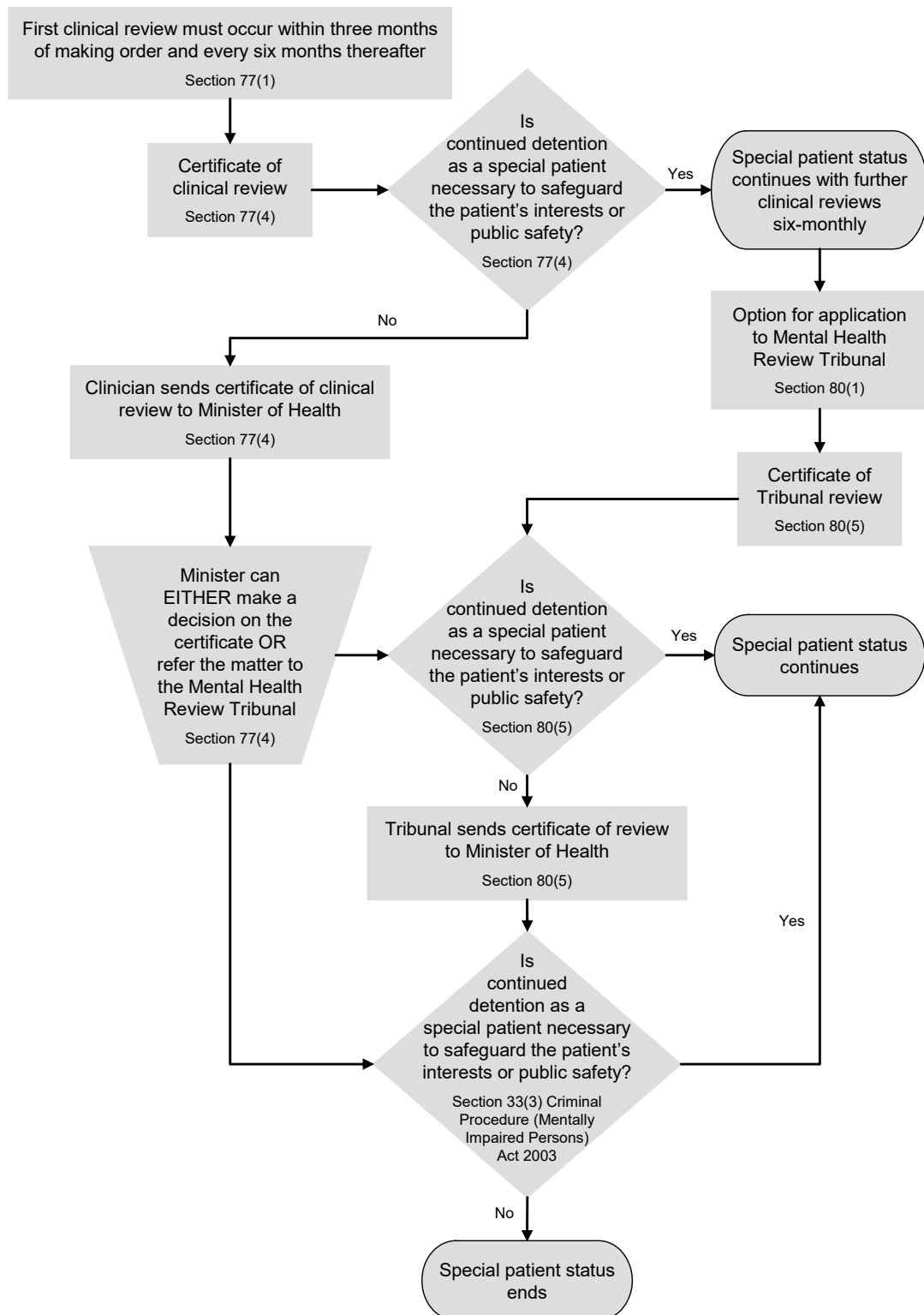


Figure 5: Clinical and judicial review of special patients found unfit to stand trial

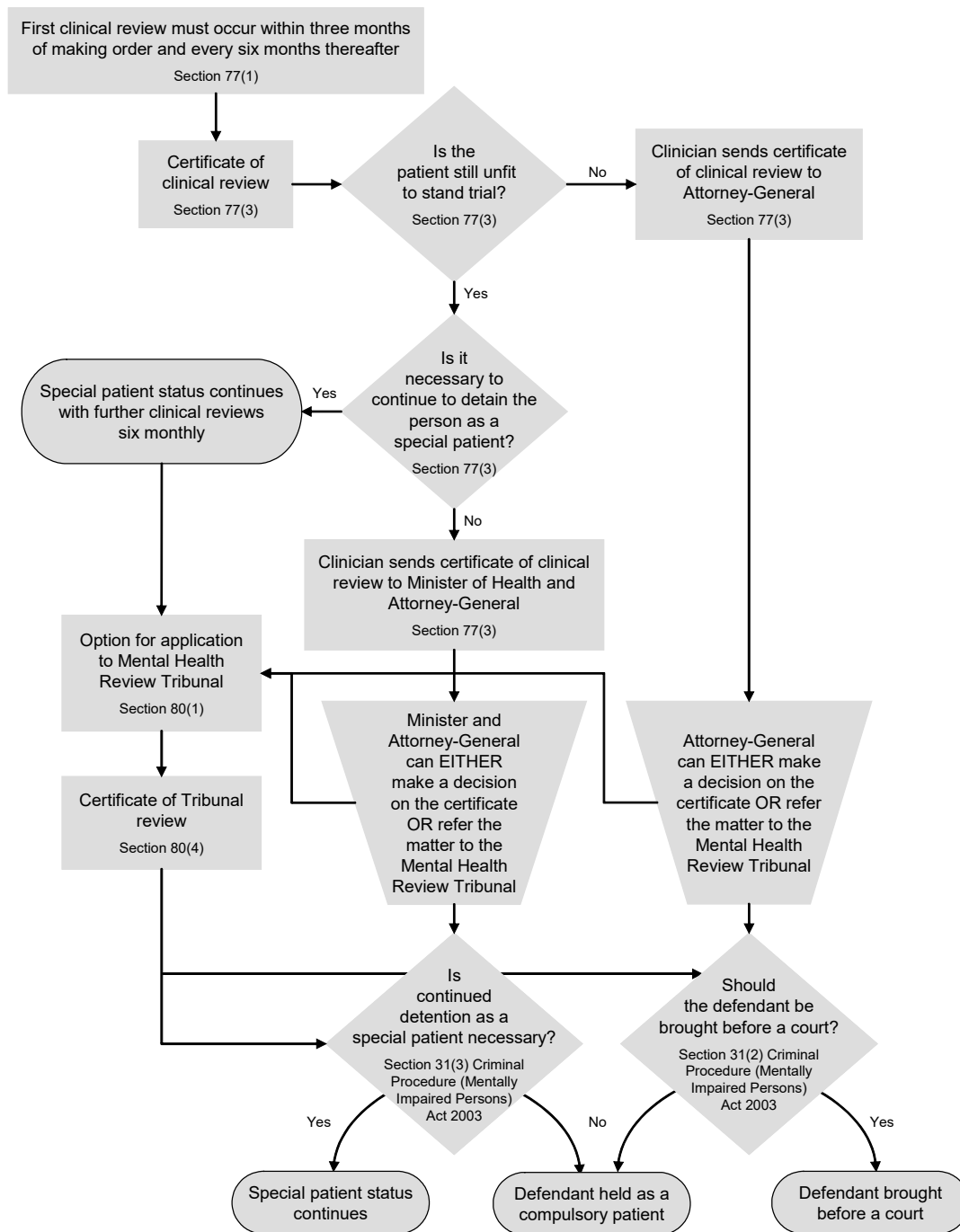
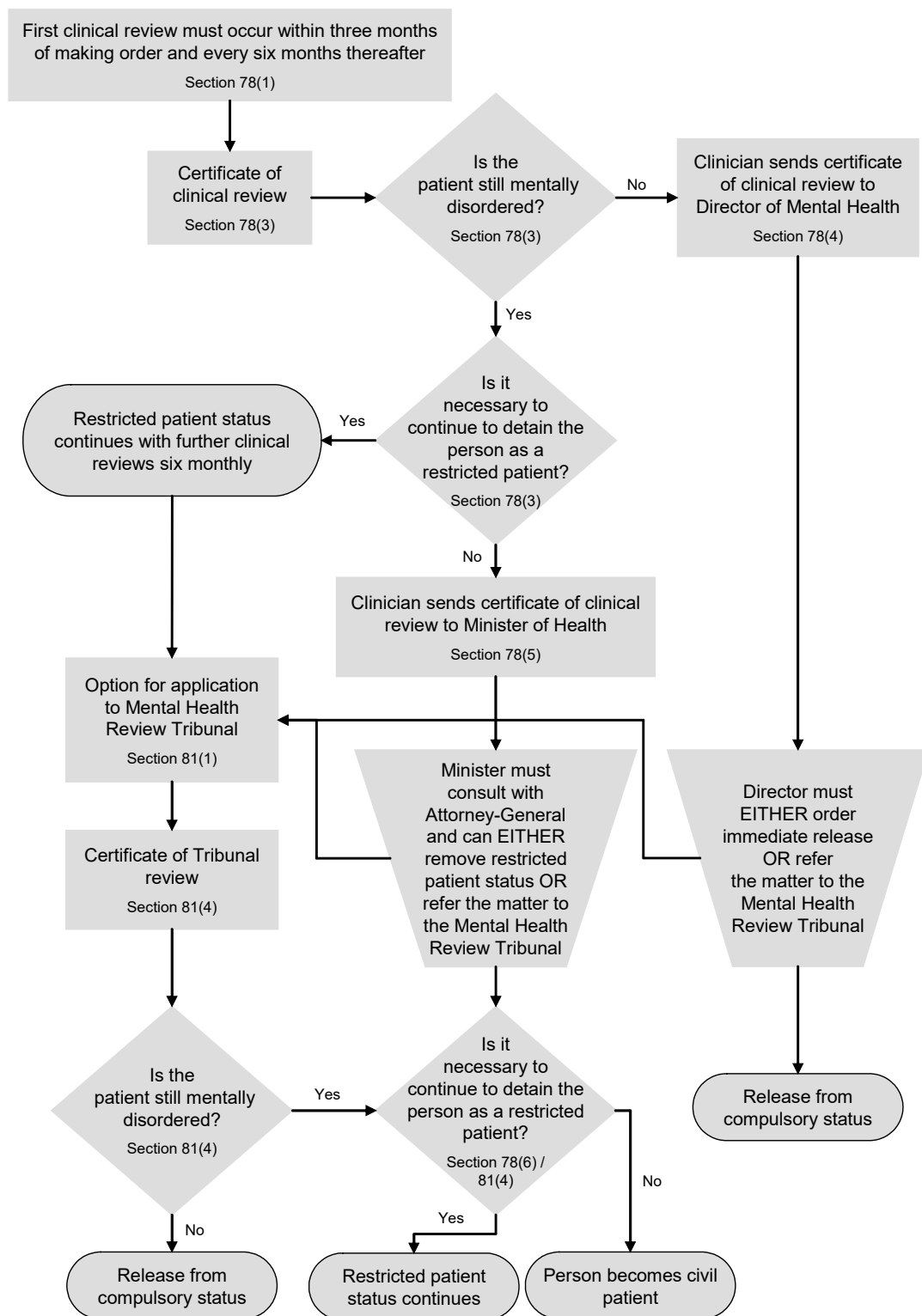


Figure 6: Clinical and judicial review of restricted patients



13 Part 8: Special provisions relating to children and young persons

At times, a child or young person is so severely unwell that they require inpatient mental health care. It is important that models of care and treatment support their recovery, taking into account their living situation, cultural identity, and spiritual and social circumstances. In 1993, Aotearoa New Zealand ratified the United Nations Convention on the Rights of the Child (UNCROC), which sets out the rights of children (up to the age of 18 years) in international law.¹³⁹

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

- the consent of a parent or guardian for any assessment or treatment is not sufficient consent for the purposes of the Act
- ‘wherever practicable’, a psychiatrist with expertise in child psychiatry should carry out the first examination of a child or young person under the age of 17 years
- when the Review Tribunal reviews a child or young person’s condition, at least one member of the Review Tribunal should be someone specialising in child psychiatry
- brain surgery for mental disorder must not be performed on any person who is under the age of 17 years (regardless of the provisions in Part 5 or section 87)
- the responsible clinician must review a young person’s case no later than one month before their 17th birthday, if they are still under a compulsory treatment order.

For all practical purposes of giving consent, a young person aged 16 or 17 years may be treated as if they are an adult, as section 87 of the Act reiterates. The Care of Children Act 2004 gives a young person who is 16 years or over the right to give or refuse consent to medical treatment, without needing to involve their parents. Note that ‘in respect of a patient who has attained the age of 16 years, the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of this Act’ (section 87).

¹³⁹ United Nations Convention on the Rights of the Child. 1990. URL: <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx> (accessed 31 July 2020).

A child or young person under the age of 16 years may also give valid and effective consent if they sufficiently understand the significance of the proposed treatment. Whether they have this understanding depends on the maturity of the child or young person, the effect of their assessed abnormal state of mind characterised by delusions or by disorders of mood or perception or volition or cognition, and the seriousness of the matter for decision. If a child or young person under the age of 16 years is unable to give consent, the consent of a parent or guardian is necessary (except in an emergency or as authorised by sections 57 to 59 of the Act).

It is important to bear in mind that family and whānau have a central role in caring for children and young people who are mentally ill. Responsible clinicians should involve family or whānau in the care and support of such patients. Note that the requirement to fully inform the patient about the treatment (as described in 11.4: 'Section 67: Right to be informed about treatment' above) does not change even if clinicians are seeking consent to treatment from a parent or guardian.

The Ministry of Health's *Consent in Child and Youth Health: Information for practitioners* emphasises respecting the rights of children and young people as individuals. It also recognises that:

Children's and young people's developing sense of identity and uniqueness is intricately bound up with the dependent and interdependent relationships they have with their parents, wider family, whānau [and hapū and iwi] and important aspects of their community, in particular their cultural and religious heritage.¹⁴⁰

Further, the UNCROC (Article 13) and Convention of the Rights of Persons with Disabilities (Article 7) specify that children are entitled to receive information of all kinds in a format that is appropriate for them and to receive the support they need to express their views.

Along with this chapter, please read the companion document to these guidelines, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. It offers guidance to thinking about and applying a human rights approach and supported decision-making in the context of implementing the Act. It also sets out how DHBs and service providers can comply with Article 37(c) of the UNCROC.

For more information about promoting children's health, see: Ministry of Health 2014, *Well Child/Tamariki Ora Programme Practitioner Handbook: Supporting families and whānau to promote their child's health and development*, Wellington: Ministry of Health. This handbook guides practitioners on how to support families, whānau and caregivers to maximise their children's health. Pages 215–218 offer practical suggestions for a service that considers children of parents with severe or untreated mental illness or addiction may be at risk, while taking account of the needs of the whole family.

¹⁴⁰ Ministry of Health. 1998. *Consent in Child and Youth Health: Information for practitioners*. Wellington: Ministry of Health.

14 Part 10: Enforcement powers and offences

Under the Mental Health Act, Police have a role in protecting an individual, as well as the public, if they have a reasonable belief that the person may be mentally disordered. The following guidance focuses on the need for Police to be able to protect the individual, the public and staff at services, rather than on a DAO's power to request Police assistance.

Under section 109 of the Act, a constable can take a person to a Police station, hospital or some other appropriate place if:

- the person is found wandering at large in any public place and acting in a manner that gives rise to a reasonable belief that they may be mentally disordered, and
- the constable then believes that it would be desirable in the interests of the person or the public to take them to that place.

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

Note that a mental health practitioner must also make every reasonable effort to get the advice and assistance of a DAO first, before requesting Police assistance. This requirement applies particularly if the process concerns a person being assessed under the Act. Clinicians should use Police assistance only as a last resort and must only use it for one of the purposes described above. Police **cannot** assist with the treatment of a patient or proposed patient.

The only other circumstances in which a service may engage the assistance of Police is if a situation that arises falls within their jurisdiction as described under section 9:

Functions of Police in the Policing Act 2008. This jurisdiction includes:

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

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

Under section 110 of the Act, a mental health practitioner may ask Police for help to conduct an examination (section 8B). A mental health practitioner acting under this section must make every reasonable effort to obtain the advice and assistance of a DAO first, before requesting the assistance of Police.

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

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

The medical practitioner must have reasonable grounds for believing that the proposed patient presents a significant danger to self or to others and that it is in the proposed patient's interests to receive a sedative drug urgently.

The medical practitioner may administer the drug and, if they do so, they must follow relevant best practice guidelines and standards of care and treatment provided by their professional and registration bodies.

The medical practitioner must make every reasonable effort to obtain the advice and assistance of a DAO, this may require a decision to call for paramedic or Police assistance specifically in relation to the safe transportation of an agitated or sedated person. This must include the responsibility for monitoring the effects of sedation, and the persons vital signs.

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

It is recognised that this is a very restrictive intervention, and requires the medical practitioner to balance human rights, clinical safety and ethical considerations when prescribing urgent sedation under this section.

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

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

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

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

Section 113 of the Act sets out these powers of detention. This detention cannot be for more than six hours from the time the nurse first calls for a mental health practitioner to examine the person (section 111(3)). Note that the power to detain is not limited to the premises of a psychiatric unit and should be exercised with discretion, according to good clinical practice.

Section 111 can be used when a voluntary inpatient seeks to leave a psychiatric unit at a time when no mental health practitioner is available to assess them, and a nurse believes that the person is mentally disordered. We advise that if a nurse detains a voluntary patient because they believe that the patient is mentally disordered, they communicate this decision with the patient. It follows that the patient's right to revoke a voluntary admission is subject to the nurse's view that the patient may be mentally disordered, and it may be desirable for the patient to have an assessment examination. A completed voluntary inpatient form ought to be sent to the district inspector for further explanation and discussion with the patient.

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

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

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

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

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

In practice, the staff of the hospital will exercise the powers given to the 'person in charge of the hospital'. The person in charge should ensure that the staff understand these powers and are properly trained to carry them out as safely as possible.

Detention may sometimes require the use of force. This force should be only to the extent necessary to detain a patient safely. If it is needed, physical restraint or seclusion must be carried out following relevant standards and guidelines.¹⁴¹ Staff must consider cultural differences when using force, for example by avoiding contact with the head of a Māori patient or proposed patient, if reasonably practicable.

14.6 Section 113A: Judge or registrar may issue warrant

Section 113A of the Act authorises a District Court Judge or Registrar to issue a warrant authorising Police to apprehend any person who refuses to attend for an assessment examination as instructed by notices under section 9, 11, 13 or 18, or a hearing under section 19 of the Act, or a clinical review under section 76 of the Act. Police may then take that person to a place specified for such an examination to be carried out. The

¹⁴¹ See Ministry of Health, 2010, above note 129; and the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008).

same power is given for Police to apprehend any patient refusing to attend a hospital in line with a compulsory treatment order or a place of treatment in line with a community treatment order.

The DAMHS or their representative must make the application. Section 113A(4) of the Act does not confer a general power to seek a warrant to apprehend any person who is not cooperating with mental health services or hospital authorities.

A DAMHS may apply to the District Court for a warrant to authorise any constable to take a *patient* or *proposed patient* to a place specified in the warrant (section 113A(3) and (4) of the Act). A District Court Judge, or Registrar if a Judge is not available, may only grant such a warrant if they are satisfied that:

- the *proposed patient* or *patient* is refusing to attend at the place at which they are required to attend; or
- the *patient* is absent from the hospital without leave, or the *patient's* leave of absence from the hospital has expired or has been cancelled.

It is recommended that a DAMHS apply for such a warrant where a DAO cannot safely exercise their powers relating to a *patient* or *proposed patient* under section 40(2) without Police assistance and it is reasonably practicable to obtain a warrant (that is, it is not an urgent or emergency situation). If the Police need to enter the premises where the *patient* or *proposed patient* is under section 41(2), the police must apply for a warrant to enter the premises (section 113A(7), the Act).

Further detail on the warrant application process can be found in the Guidelines for the Role and Function of Statutory Officers Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 available on the Ministry of Health Website.

14.7 Section 122B: Use of force

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

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

The use of force should always be considered a last resort. Clinicians should be able to demonstrate that they considered and attempted conflict resolution and de-escalation approaches before using coercion. Any person using force may be criminally responsible if excessive force is used.¹⁴²

'Force' includes every touching of a person for the purposes of compelling or restricting movement or administering treatment. It will normally be appropriate for clinicians to use minimal force when exercising one of the powers above. 'Minimal

¹⁴² See section 62 of the Crimes Act 1961.

force' means light or non-painful touching, for example, to guide a person towards a building or room or to help a person into or out of a vehicle.

There is a clear division of roles between DAOs/Mental Health Practitioners and Police officers. A DAO/Mental Health Practitioner is responsible for the patient; Police for keeping the peace and maintaining safety. In urgent situations requiring Police assistance, the DAO is considered to be the official in charge. The Act allows a DAO to use reasonable force under the provisions of section 122B. When a DAO requests Police assistance, they need to ensure the Police approach is not unduly restrictive, for example, by using handcuffs on patients.

Particular care should be taken with patients who may be more susceptible to pain (such as elderly patients or patients with hyperalgesia).

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

- take a person for an examination by a mental health practitioner (section 38(4)(d))
- take or return a patient or proposed patient to a place of assessment or treatment (section 40(2))
- return a special patient to hospital (sections 50(4), 51(3) and 53)
- detain a person in hospital for a mental health practitioner to examine if they are thought to be mentally disordered (section 111(2)).

When someone uses more than minimal or inconsequential force while exercising a power under the Act, a DAO must complete a log recording the circumstances and forward it to the DAMHS as soon as practicable. A log for this purpose should include:

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

Services should refer to the Manatū Hauora Ngā Pirihimana o Aotearoa: Memorandum of Understanding (MOU) between the Ministry of Health and New Zealand Police which is available on the Ministry of Health website. This MOU provides guidance to Police and health professionals administering the provisions of the Act, as well as any local agreements made under the Memorandum of Understanding. For detailed guidance around the use of force by DAOs, see: Ministry of Health. 2022 *Guidelines for the Role and Function of Statutory Officers Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health. This can be accessed online on the Ministry of Health website.

14.7.1 Use of force to administer compulsory treatment

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

The use of force is not permitted if the responsible clinician has failed to properly seek consent when establishing or changing treatment or failed to obtain a concurring second opinion where the patient did not give consent. If someone administers treatment without complying with Part 5, it could be considered an assault in law.

These guidelines apply to anyone who is using force in line with the Act. Those who are required to use force for the purposes of the Act must follow the principles set out in 14.7.3: 'Principles on the use of restraint' below.

14.7.2 Use of restraint

The Ministry recognises that seclusion and restraint have no therapeutic value and may be traumatising for both patients and staff. The Ministry supports a reduction in the use of restraint in mental health services over time, as well as the Mental Health and Addiction Quality Improvement Programme *Zero seclusion: Safety and dignity for all* | *Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha* project. The use of restraint is a last resort that should be avoided wherever possible through the use of less restrictive practices, such as those promoted through Safe Practice Effective Communication (SPEC) training. Where restraint cannot be avoided, it must be done safely.

The ability to use force when exercising a power under the Act implies that in some cases restraint may reasonably be used. Section 6 here taratahi (restraint and seclusion) of the Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021). Ngā Paerewa defines restraint as “the use of any intervention by a service provider that limits a person’s normal freedom of movement”. This standard also defines seclusion as, “where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit”.

Services should note that when a patient is in a room or area from which they cannot freely exit, they should record and report this as seclusion, regardless of whether the DAMHS has designated the room as a seclusion room (section 71(2)(b)).

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

14.7.3 Principles on the use of restraint

Restraint is an intervention of last resort used with the least amount of force necessary when all other options have failed to maintain safety for the person experiencing distress, staff or others in the inpatient environment. The duration of a restraint must be the shortest possible time it takes to safely manage the situation and must be guided by legal, ethical and trauma-informed care principles. All restraint events and episodes must be reviewed, and the staff involved must detail the circumstances leading up to the restraint and explain the rationale for restraining the person.

To optimise the physical safety of the person being restrained, these guidelines endorse current SPEC training principles, which do not include flexion based (painful) techniques and avoid, wherever possible, the use of prone positioning (lying the person face down) due to the increased risk of injury and positional asphyxiation.

The decision to use restraint is based on a duty of care in an emergency. Restraint is only used to manage significant risk to patients and potential patients, people accessing the service, staff or others and as an emergency intervention when all other least restrictive strategies and approaches have been tried without positive effect.

Services are required to work to address the environmental issues that drive the use of restraint. These may include building design, noise levels, line of sight and other issues.

Services are required to work to address systemic issues that drive the use of restraint. These include organisational skills and experience, workplace culture and workforce practice.

If a restraint occurs, staff must be mindful of upholding the patient's dignity, privacy and mana at all times. They must address any breaches of the above with the patient or potential patient as soon as it is practicable to do so.

Every person accessing services has the right to be provided with services that take into account the needs, values and beliefs of different cultural, religious, spiritual, social and ethnic groups, including the needs, values and beliefs of Māori.¹⁴³

Services must receive training and implement operational policies and strategies in culturally competent best-practice approaches that positively and authentically address the high rates of restraint used for Māori and Pacific patients or potential patients.

Services are required to ensure that the workplace meets required health and safety standards, and to ensure agreed minimum staffing ratios in each workplace to provide safe and effective care to patients. This includes agreements to increase staffing levels when the level of acuity in the workplace increases to a point that it is unsafe for staff and patients.

¹⁴³ Code of Health and Disability Services Consumers' Rights 1996.

14.7.4 Working in partnership with Māori

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

14.7.5 Requirement to keep register and to report

Section 122B(4) of the Mental Health Act states that in circumstances in which staff use force under the Mental Health Act, they must record this as soon as is practicable and provide the record to the DAMHS. Under section 129(1)(b) of the Mental Health Act, the DAMHS must ensure that in every hospital or service, the person in charge keeps a register of restraint and seclusion of patients subject to the Mental Health Act.

Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021) require district health services to collect detailed data on restraint activity. Accordingly, this data should include:

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

Since 1 July 2020, mental health services have been required to report their use of restraint to the Ministry of Health. Services will initially report their use of restraint via DAMHS quarterly reporting, until mechanisms to report via PRIMHD are established.

More detailed information will be available from December 2022 when the revised guidelines for reducing and eliminating seclusion and restraint under the mental health (compulsory assessment and treatment) act 1992 will be available on the Ministry of Health website.

14.8 Section 114: Neglect or ill-treatment of patients or proposed patients

It is an offence under section 114 of the Act to intentionally neglect or ill-treat patients or proposed patients. This section applies to:

- the person in charge of the hospital or service where a proposed patient attends for the assessment examination
- the person in charge of a hospital in which the patient is an inpatient
- a person employed in a hospital or service engaged in the assessment of a proposed patient or treatment of a patient
- the person in charge of a home, house or other place where a patient or proposed patient resides.

Such an offence is punishable on conviction by a prison sentence no longer than two years.

Appendix 1:

Recommended guidelines and other documents

Many of the guidelines below are available on the Ministry website (www.health.govt.nz) as current publications or archived in the Ministry of Health Online Library Catalogue, or can be ordered in hard copy, unless otherwise specified.

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

Huriwai T, Baker M. 2016. *Manaaki: Mana enhancing and mana protecting practice*. Wellington: Te Rau Matatini. URL: <https://terauora.com/wp-content/uploads/2019/05/Manaaki-Mana-Enhancing-and-Mana-Protecting.pdf> (accessed 1 August 2020).

Māori Advisory Group. 2020. Mental health and addiction quality improvement programme: tools and resources provided by the group as at 2018. Wellington: Health Quality & Safety Commission. URL: <https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/publications-and-resources/publication/3600/> (accessed 1 August 2020).

Ministry of Health. *Guidelines for the Role and Function of Statutory Officers Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington. Ministry of Health. (Online only.)

Ministry of Health. 2021. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Wellington: Ministry of Health.

Ministry of Health. 2009. *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know*. Wellington. Ministry of Health.

Ministry of Health. 2009. *Victim Notification Guidelines for Directors of Area Mental Health Services and DHB Victim Notification Co-ordinators*. Wellington. Ministry of Health. (Online only.)

Ministry of Health. *Guidelines for Reducing and Eliminating Seclusion and Restraint under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington. Ministry of Health. (Online only.)

Ministry of Health. 2011. *Mental Health and Addiction Services for Older People and Dementia Services: Guideline for district health boards on an integrated approach to mental health and addiction services for older people and dementia services for people of any age*. Wellington. Ministry of Health.

Ministry of Health. *Guidelines for the Role and Function of District Inspectors: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington. Ministry of Health. (Online only.)

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

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Ministry of Health. *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services*. Wellington. Ministry of Health. (Online only.)

Ministry of Health. 2020. *Office of the Director of Mental Health and Addiction Services Annual Report 2017*. Wellington. Ministry of Health.

Ministry of Health. 2020. *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington. Ministry of Health.

Ministry of Health. 2020. *Whakamaui: Māori Health Action Plan 2020–2025*. Wellington. Ministry of Health.

RANZCP. 2000. *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes*. Wellington. Ministry of Health. (Online only.)

Ryan D, Grey C, Mischewski B. 2019. *Tofa Saili: A review of evidence about health equity for Pacific peoples in New Zealand*. Wellington: Pacific Perspectives Ltd.

Southern Health. Mental Health Advance Preferences Statement. URL: <https://www.southernhealth.nz/getting-help-you-need/mental-health-and-addictions/mental-health-advance-preferences-statement> (accessed 1 August 2020).

Te Pou o te Whakaaro Nui. 2017. *Real language, real hope*. URL: <https://www.tepou.co.nz/resources/real-language-real-hope/790> (accessed 1 August 2020).

Todd FC. 2010. *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems*. Wellington. Ministry of Health.

Waitangi Tribunal. 2019. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. Wellington: Legislation Direct.