Review of the Application of Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992
Contents

Executive Summary v

Background to this Review 1
  Roles and rights of people experiencing mental illness and their family/whānau 1
  Consultation and the Mental Health (Compulsory Assessment and Treatment) Act 1992 1
  Role of Ministry of Health 1
  Perceived ongoing lack of consultation 1
  Terms of review 2

Content of Report 3
  Literature and legislation review 3
  Audit of clinical files 3
  Survey of responsible clinicians 3
  Experiences and views of interested groups and individuals 4
  Review of section 7A’s application and Ministry of Health guidelines 4
  Recommendations 4

Literature and Legislation Review 5
  Methodology 5
  Results from the literature review 5
  Australian legislation 6
  European Union 8
  World Health Organization 9
  Summary of literature and legislation reviews 10

Audit of Clinical Files 12
  Introduction 12
  Methodology of audit 12
  Results of audit 13
  Discussion 16

Survey of Responsible Clinicians 18
  Introduction 18
  Methodology of survey 18
  Results of survey 18
  Discussion 22

Experiences and Views of Interested Groups and Individuals 24
  Methodology 24
  Submissions received 24
  Summary 26
Review of Section 7A’s Application, particularly Consultation with Principal Caregivers

Amendment to section 7A
Concepts of ‘reasonably practicable’ and ‘best interests’
Practices outside the Ministry of Health guidelines
Training experiences
Exposure to Ministry of Health guidelines and other resources
New clinical report form
Consultation with ‘principal caregiver’
Family/whānau attendance at court hearings

Review of Ministry of Health Guidelines to Ensure Adequate Information about Principal Caregiver’s Role and for Caregivers

Overview
Revision of guidelines
Cultural issues
Distribution of guidelines

Recommendations

Summary

Appendices

Appendix A: Section 7A of the Mental Health (Compulsory Assessment and Treatment Act 1992
Appendix B: Search Sources and Strategies (as provided by New Zealand Health Technology Assessment)
Appendix C: Key Papers from Literature Review
Appendix D: World Health Organization Checklist on Mental Health Legislation (extract)
Appendix E: Email Survey of Responsible Clinicians
Appendix F: People and Organisations who Made Submissions
Appendix G: Guidelines to the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (section 1.4)
Appendix H: Guidelines to the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (section 4)

References

List of Tables

Table 1: Distribution of section 10 assessments reviewed in the audit by District Health Board
Table 2: Reasons for no consultation with family/whānau
Table 3: Country of main training in mental health for responsible clinicians
Table 4: Training experiences of responsible clinicians

List of Figures

Figure 1: Family/whānau consultation
Executive Summary

Obligation to consult family/whānau

A 1999 amendment to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) made consultation with a patient’s (or proposed patient’s) family/whānau compulsory during the assessment and treatment of the patient (section 7A) in addition to pre-existing notification requirements.

Consultation with a patient’s or proposed patient’s family/whānau must take place during the patient’s assessment and treatment unless it is not reasonably practicable to do so or is not in the patient’s best interests.

Role of Ministry of Health

The Ministry of Health is responsible for administering the MHA, which allows for the publication of guidelines to which clinicians must adhere. The Ministry has published Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2000) and Involving Families: Guidance notes (RANZCP 2000).

Review to address perceived lack of consultation

A perceived lack of consultation by clinicians with families/whānau or principal caregivers has been an ongoing issue even since the introduction of section 7A.

To address this concern the Health Select Committee recommended that the Ministry of Health:

- review the application of section 7A, particularly in relation to consultation with principal caregivers
- review the guidelines to ensure they provide adequate information about the principal caregiver’s role, including the information that should be provided to caregivers.

The Ministry’s recommendations result from a literature and legislation review to determine international best practice, an audit of clinical files to assess current practice, a survey of responsible clinicians, and submissions from interested groups and individuals.

Recommendations

The broad consensus was that section 7A allows for adequate consultation.

The involvement of family/whānau extends beyond any legislative demands, being a part of best clinical practice. Therefore, the Ministry of Health’s recommendations, rather than focusing on legislative change, focus on developing a wider culture of family/whānau consultation that takes into account the circumstances of the clinical situation and an individual’s rights.

The recommendations arising from this review are as follows.
Legislation

1 Section 7A of the MHA is not amended.

Revisions to guidelines

2 The Ministry of Health guidelines are revised to:
   - further define ‘consultation’, ‘reasonably practicable’ and ‘best interests’
   - provide practical examples of the defined terms
   - address consultation for assessments late at night or after hours
   - address consultation by people other than the responsible clinician
   - clarify when consultation should occur, including consultation at the section 12 stage
   - discuss the different mechanisms for consultation (eg, in person or on the phone)
   - discuss family/whānau attendance at court hearings
   - include the principal caregiver as a family/whānau member
   - address guardianship and principal caregiver issues.

Distribution of guidelines

3 A strategy for releasing the revised Ministry of Health guidelines is developed.

4 Other resources (eg, guidance notes (RANZCP 2000)) are redistributed to responsible clinicians.

Training

5 Responsible clinicians are given opportunities to attend a Mental Health Workforce Developmental Programme workshop on involving family/whānau in MHA processes.

6 Clinicians are given more training and better access to resources about the MHA, particularly clinicians:
   - arriving from overseas
   - being appointed as responsible clinicians.

Information

7 The new clinical report form is used consistently throughout the country.

8 More information is given to family/whānau and principal caregivers about, for example:
   - the provision for family/whānau consultation under section 7A
   - opportunities to attend court hearings.
Background to this Review

Roles and rights of people experiencing mental illness and their family/whānau

Families and whānau often have a significant amount to offer family members who experience mental health problems. They can be invaluable sources of information and support, and important partners in a person’s treatment and management plans. Good clinical care necessitates their role be considered.

However, the rights of a patient and the rights of their family/whānau may conflict, so clinical teams need to balance them carefully. While respecting patient autonomy remains a fundamental ethical principle, several high profile cases have heightened awareness of the rights of family/whānau among the general population as well as among families of people experiencing mental illness.

Consultation and the Mental Health (Compulsory Assessment and Treatment) Act 1992

Before a 1999 amendment to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), clinicians were required at certain stages of the MHA process to send a patient’s principal caregivers and guardians copies of certain documents (eg, the section 10 certificate of preliminary assessment and section 14(4) application for compulsory treatment order), but they were not required to ‘consult’ caregivers and guardians.

The 1999 amendment introduced section 7A (reproduced in Appendix A) and made consultation with family/whānau compulsory during both the assessment and treatment of patients (or proposed patients) under the MHA (in addition to the pre-existing requirements). Section 7A states that consultation with a patient’s (or proposed patient’s) family/whānau must take place during the patient’s assessment and treatment unless it is not reasonably practicable to do so or is not in the patient’s best interests.

Role of Ministry of Health

The Ministry of Health is responsible for administering the MHA, which allows for the publication of guidelines to which clinicians must adhere.

To guide clinicians on how to consult with family/whānau the Ministry published Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2000) and Involving Families: Guidance notes (RANZCP 2000).

Perceived ongoing lack of consultation

The lack of consultation with families/whānau or principal caregivers featured as a perennial issue in inquiries in the mental health sector before the 1999 amendment (eg, Mason et al 1996). This concern has continued to be raised since the amendment (eg, Health and Disability Commissioner 2002; Ministry of Health 2003).
In 2002 a parliamentary petition (2002/17) requested the MHA be amended to extend the circumstances where indefinite orders apply. In 2003 a private member’s Bill was proposed (the Mental Health (Compulsory Assessment and Treatment – Family Involvement in Assessment and Release) Amendment Bill).

The Health Select Committee, which considered the parliamentary petition, recommended that the Ministry of Health review the application of section 7A to determine whether it had increased consultation with family/whānau. This review is the result of that recommendation.

**Terms of review**

The Health Select Committee’s recommendations form the terms of the review.

- Review the application of section 7A of the MHA, particularly in relation to consultation with principal caregivers.
- Review the guidelines issued under section 130(a) of the MHA to ensure they provide adequate information about the principal caregiver’s role, including the information that should be provided to caregivers.
Content of Report

This report includes:

- a review of the literature and legislation from comparable jurisdictions
- an audit of clinical files
- a survey of responsible clinicians
- a description of the experiences and views of interested groups and individuals
- a review of section 7A’s application, particularly in relation to consultation with principal caregivers
- a review of the Ministry-published guidelines (Ministry of Health 2000; RANZCP 2000) to ensure they include adequate information about the principal caregiver’s role and the information to be provided to caregivers
- recommendations.

A summary of the review, appendices containing background information and references conclude the report.

Literature and legislation review

The Ministry of Health commissioned from New Zealand Health Technology Assessment (NZHTA) a review of the literature about involving the families of people with mental disorder and substance use disorder in the process of compulsory assessment and treatment.

Legislation from Australia and Europe was reviewed to see whether and how it included families and caregivers during mental health Act processes.

Audit of clinical files

Clinical files pertaining to applications under the MHA during November and December 2004 were audited for quantitative data on current practice in relation to family/whānau consultation.

No comparable data existed before the introduction of section 7A. However, the audit indicates how clinicians around New Zealand are interpreting and implementing section 7A during the initial process of compulsory assessment.

Survey of responsible clinicians

An email survey of responsible clinicians was undertaken to collect their experiences and views (see Appendix E). Information was collected about their background, changes in practice since the introduction of section 7A, training experiences and views about the amendment and guidelines.
Experiences and views of interested groups and individuals

The views and experiences of a variety of relevant organisations and individuals were sought directly, for example from district inspectors, the RANZCP, the New Zealand College of Mental Health Nurses, the Association of Psychologists, the Mental Health Commission, the Health and Disability Commissioner, and Family and Service User Groups. Submissions were also received from other groups and individuals.

The individuals and organisations from whom submissions were received are listed in Appendix F.

Review of section 7A’s application and Ministry of Health guidelines

Section 7A’s application is reviewed, particularly in relation to consultation with principal caregivers, and the Ministry of Health guidelines are reviewed to ensure they provide adequate information about the principal caregiver’s role, including the information that should be provided to caregivers.

Recommendations

Recommendations are made in relation to training, workforce issues, clinical reporting and revisions to the Ministry of Health’s guidelines.
Literature and Legislation Review

Methodology

The Ministry of Health commissioned the NZHTA to search the literature for publications about involving the families of people with mental disorder and substance use disorder in the process of the person’s compulsory assessment and treatment.

The literature search was undertaken in December 2003 and repeated in July 2005. The search sources and strategies are listed in Appendix B and key papers are listed in Appendix C.

The NZHTA reported that the topic was difficult to search. Although a relatively large amount of literature (197 items) was found about committal and compulsory treatment and about family therapy and involvement in mental illness, little was found about family involvement in committal and compulsory treatment processes.

The Australasian Legal Information Institute (AustLII) database was searched to find the current Australian mental health Acts and to identify any legislative requirements for involving family/whānau in a family member’s compulsory assessment and treatment (http://www.austlii.edu.au/).

A review of legislation and practice in European Union (EU) member states (Salize et al 2002) and the WHO Resource Book on Mental Health, Human Rights and Legislation (WHO 2005) were also considered.

Results from the literature review

No significant evidence base for best practice in family involvement in compulsory assessment and treatment was identified.

The main findings from the key papers (listed in Appendix C) are as follows.

- Families/whānau have an important role in the recognition and treatment of mental illness in their family member.
- The burden on the family of a person experiencing mental illness is considerable.
- Interacting with the legal system is a significant problem for families.
- Older papers reported that family members’ views are dissimilar to the views of patients, clinicians and the public. However, more recent research, (including on the role of coercive treatments) does not reflect this.
- Models of the family’s role in a family member’s assessment and treatment are varied and sometimes opposing.

Notwithstanding the limited evidence about family involvement in compulsory assessment and treatment, there is a great deal of research demonstrating that family psycho-education is an evidence-based practice shown to reduce relapse rates and facilitate recovery of mentally ill persons (Dixon et al 2001)
Contemporary clinical guidelines, such as those developed by the National Institute for Clinical Excellence in the United Kingdom, devote a whole section to family interventions in their full national clinical guideline on core interventions in primary and secondary care for schizophrenia. The RANZCP guideline also highlights the importance of family/whānau therapy, citing research which shows that recovery is aided if treatment is a collaborative endeavour between clinicians, family/whānau and the consumer/tangata whai ora.

**Australian legislation**

In Australia each territory or state has its own mental health or equivalent Act. The following discussion uses the terms used in each jurisdiction’s legislation. Although the terms have their own, often unique, meaning, they are broadly equivalent to the New Zealand concept of ‘family/whānau’.

Generally, the term ‘relative’ is used rather than ‘family’ and is defined as a specific group of people (usually the patient’s blood relatives or the patient’s partner’s blood relatives). For example, in the Australian Capital Territory ‘relative’ means, in relation to a person, ‘a domestic partner, parent, guardian, grandparent, uncle, aunt, brother, sister, half-brother, half-sister, cousin or child’ of the person.

**Australian Capital Territory**

The Australian Capital Territory’s Mental Health (Treatment and Care) Act 1994 uses the term ‘relative’, but has no specific requirement for the clinical team to consult relatives.

A person admitted under a treatment and care order must be given adequate opportunity to contact or notify his or her family.

A care co-ordinator must consult and notify a guardian or power of attorney (if one has been allocated) of a person under a community care order.

The Mental Health Tribunal must consult, as far as practicable, the people with parental responsibility of a person if the person is a child.

One of the Act’s objectives is that the territory, in providing services and facilities, consults people who are receiving treatment, their carers and the community about general aspects of service provision, development and review.

**New South Wales**

In New South Wales the Mental Health Act 1990 does not have a specific requirement to consult relatives. The medical superintendent or other medical practitioner may take into account any available evidence he or she considers reliable and relevant, but does not have to consult a person’s family.

Relatives or friends may request a patient’s detention or discharge.
The medical superintendent must, as far as reasonably practicable, give notice to a patient’s nearest relative of intentions to bring the patient before a magistrate and of other formal processes, unless the patient objects to this.

Queensland

In Queensland the Mental Health Act 2000 has no specific requirement for consultation with family members in relation to a person’s involuntary treatment.

A patient may choose a relative or friend to act as an ‘allied person’ to help represent the patient’s views and wishes. The allied person is given notice of formal proceedings and may attend hearings.

Western Australia

In Western Australia the Mental Health Act 1996 contains little about the rights of family or carers. The only rights in relation to family members are for the patient to have access to post, telephone and visitors. There is no requirement for family to be consulted.

The Mental Health Review Board may accept applications for discharge from the patient or any other person who, in the board’s opinion, has a ‘proper interest’ in the matter.

South Australia

In South Australia the Mental Health Act 1993 requires the notification of relatives whose whereabouts are known or readily ascertainable by the director (ie, the person authorised to admit patients to the treatment centre) at various points in the process, unless the director is of the opinion it would not be in the patient’s best interests to do so. Notification includes giving relatives a statement of the patient’s rights on the patient’s initial admission.

Tasmania

In Tasmania the Mental Health Act 1996 states a ‘person responsible’, who may be a family member, along with the patient, is provided certain information about the patient’s condition, proposed treatment and legal status. For patients aged 18 and over the ‘person responsible’ is identified in a priority list of guardian, spouse, person having the care of the patient, or a close friend or relative of the patient.

The legislation does not explain what happens when there is no ‘person responsible’ or if there is dispute about who is the ‘person responsible’.

Northern Territory

In the Northern Territory the Mental Health and Related Services Act 2002 states principles in relation to the rights of carers. They include that, as far as practicable and appropriate, a person’s carer must be consulted and involved in the development of the person’s ongoing treatment and discharge plans.
Notifications of admission or similar are sent to a person’s primary care provider only if the person consents. However, if the authorised psychiatric practitioner believes a person is unable to give consent or as a result of his or her mental illness unreasonably refuses to give his or her consent, the practitioner must notify the primary care provider if the psychiatrist considers it in the patient’s best interests.

A ‘primary care provider’ is defined as a person who, because of his or her relationship with a person, whether that is through kinship, familiarity, marriage or a de facto relationship, has a sense of responsibility for that person and provides care and support for that person, whether or not they live with the patient.

**Victoria**

In Victoria, the Mental Health Act 1986 states that an authorised psychiatrist may consult with any person, including any member of the family of the person or his or her primary carer or guardian. In preparing and regularly revising a treatment plan the practitioner must take into account the wishes of any guardian, family member or caregiver who is involved in providing ongoing support or care to the patient, unless the patient objects.

**Summary of Australian legislation**

Most Australian territory and state legislation gives primary attention to patients’ rights such as ensuring their access to relatives or family.

The director of area mental health services (or equivalent) is required to notify the person’s family about mental health Act processes, although there are usually exceptions to this requirement. If a guardian or power of attorney is appointed, the legislation typically requires that person to be notified also.

A relative or friend usually has the right to apply for a person’s involuntary treatment or discharge from involuntary treatment.

The Northern Territory legislation gives the strongest demand for consultation with carers and allows a psychiatrist to notify primary care providers without a patient’s consent in certain circumstances.

**European Union**

A review of the processes in EU-member states stated that the legislation in 12 out of the 15 members stipulated that others (eg, a guardian, family member, relative or legal representative) had to be notified in the event of a person’s compulsory admission (Salize et al 2002). The three exceptions are Finland, Greece and Italy. In Greece and Italy a family member has the power to make an application for a person’s involuntary care. In nine countries legislation stipulates specifically that family members or relatives are to be informed.
A review of the processes in the countries’ Acts identified different approaches to the role of families. Most commonly the family is involved in the application for involuntary hospitalisation and may apply for the person’s release from or review of involuntary hospitalisation. However, mandatory consultation rather than notification is not routinely required.

Generally the legislation in the EU states focuses on a person’s civil rights and not family members’ rights. A comparison of German and United Kingdom legislation demonstrates the range of approaches to family involvement (Roettgers and Lepping 1999). In the United Kingdom the key powers rest with the professionals and relatives, both of whom are assumed to act benevolently in the patient’s interest. In Germany formal court decisions are required even in routine cases.

Of note, in England and Wales an approved social worker must consult with family before completing an application for a person’s treatment or admission, unless he or she considers that such consultation is not reasonably practicable or would involve unreasonable delay.

Legislation in the Netherlands places a ‘foremost obligation’ on the physician of an incompetent patient to consult a spouse, parent or family member for approval, but the physician is not obliged to act accordingly if it conflicts with their professional opinion.

The EU review also reported that in Luxembourg, ‘familial and social contact should be encouraged, if possible’ (Salize et al 2002).

**World Health Organization**

The *WHO Resource Book on Mental Health, Human Rights and Legislation* (WHO 2005) includes a checklist to assist in reviewing the comprehensiveness and adequacy of existing mental health legislation and drafting new legislation. Section E of the checklist is about the rights of families or other carers (and is reproduced in Appendix D).

Also relevant to this review is section D of the checklist, rights of users of mental health services (page 125):

2) Is the right to patients’ confidentiality regarding information about themselves, their illness and treatment included? ...
   b) Does the legislation lay down exceptional circumstances when confidentiality may be legally breached?

The key issue for the World Health Organization (WHO) is that legislation should not allow the arbitrary refusal to release information merely on grounds of confidentiality, although the extent of an individual’s right to confidentiality is likely to vary from culture to culture.
Section 7A appears to align well with the WHO checklist. By mandating for consultation it entitles families and other carers to information and encourages them to become involved in formulating and implementing the patient’s management plan. Section 7A further allows patients to refuse the divulging of information as in their ‘best interests’. However, as outlined in the Ministry of Health guidelines, this still allows for communication between clinicians and family/whānau to seek and provide information, particularly for the person’s ongoing care and to prevent a serious threat to life or health.

**Summary of literature and legislation reviews**

The literature on the topic of family/whānau involvement in involuntary commitment is limited in defining best practice. However, the importance of the role of family/whānau in the recognition and care of family members with mental illness is clear. Families/whānau have significant burdens and concerns regarding their family member with mental illness, which must be addressed. It is further evident that the legal processes around involuntary treatment are part of this burden.

The best models to facilitate family/whānau inclusion in what can be a stressful process are being debated. More research is necessary to identify best practice and support family/whānau inclusion in the care and treatment of people with mental illness.

New Zealand’s mandatory requirement for consultation with family/whānau demands greater family involvement than occurs in EU countries or Australian states, with the exception of Northern Territory. In that sense, legislation in New Zealand can be considered as being progressive in requiring family/whānau consultation during involuntary assessment and treatment, although it stops short of the mandated involvement in treatment planning that exists in Northern Territory.

Common exclusions to the requirement for consultation with family are a patient’s objection or wishes and practical issues such as when no family is known. Similarly the legislation in New Zealand covers both these circumstances in its exclusions.

Northern Territory has specifically considered the competence of a mentally disordered person to give informed consent to family consultation. In the Netherlands a physician must consult a family member of an incompetent patient. In New Zealand, the requirement for the practitioner to consider whether consultation with family/whānau is in the patient’s best interests is an alternative approach.

Section 7A also aligns with WHO principle guidance on Ministry of Health legislation.

In summary, the legislation reviewed focuses on the rights of the patient rather than the rights of the family/whānau, while noting the importance of consulting and/or involving family/whānau. A spectrum of consultation and inclusion of family in care planning ranged from the family being only notified of certain processes to mandatory consultation to mandatory involvement.

In some jurisdictions it is necessary to consider whether consultation with family is in the patient’s best interests. Some jurisdictions allow a patient to object to their family’s involvement, but in only one jurisdiction was determining the patient’s competence considered a necessary part of this process.
Audit of Clinical Files

Introduction

Clinical files were audited to gather objective data on current practices surrounding the involvement of families/whānau as required by section 7A.

Limited information was recorded in MHA application forms and relevant information inconsistently recorded in clinical notes. Therefore, to gather a complete data set efficiently the audit was limited to the initial application of the MHA (the sections 8–10 assessment resulting in the certificate of preliminary assessment).

All District Health Boards (DHBs) where this material was recorded within MHA applications or ‘clinical report’ forms were audited, and all assessments over the two-month period November to December 2004 were included.

The audit of clinical files at the sections 8–10 stage enabled a wide sampling across regions and different DHBs and captured a variety of clinical situations (including after hours, hospital settings, community settings and police stations), a mixture of assessing clinicians with varied experiences and qualifications (eg, psychiatrists, psychiatric registrars, medical officers and general practitioners) and a range of clinical presentations.

Methodology of audit

A sample of MHA clinical report forms was reviewed from all areas in New Zealand to identify the areas collecting information relevant to section 7A, which were therefore potentially auditable. Clinical files from the office of the director of area mental health services (DAMHS) in all areas collecting section 7A data were accessed.

The criteria for inclusion in the audit were all section 8–10 applications that resulted in a positive finding of mental disorder in the opinion of the assessing medical practitioner who completed the certificate of preliminary assessment. Section 45 applications (assessments made in respect of people detained in penal institutions) were also included.

The period of the audit was November and December 2004.

Files were excluded if the section 9 examination had taken place out of area and the person had later transferred into area, because this documentation would be duplicated at the DAMHS office of origin or not be in the audited regions.

Information was collected from all files that met the inclusion criteria. It included basic demographic information (sex, age and ethnicity) and the nature of any family/whānau consultation that had occurred. When family/whānau consultation had not occurred the reasons for this and whether those reasons were compatible with the exclusions in the legislation were assessed.
Demographic data from the sample was compared with the Mental Health Information National Collection (MHINC) data for the same period to establish whether the areas sampled were representative of the country as a whole.

Consultation was defined for the purpose of this audit as contact being made with at least one family/whānau member before the completion of the section 10 certificate, confirmed by documentary evidence or a verbal report from the assessing medical practitioner.

If information about consultation with family/whānau was insufficient in the documentation the medical practitioner who completed the section 10 assessment was contacted directly for clarification.

**Results of audit**

Nine DHBs documented their compliance with section 7A in a way that was suitable for this audit (see Table 1). This represented a mix of North Island and South Island and rural and urban DHBs. The nine DHBs collectively provide services to some 36% of the New Zealand population.

<table>
<thead>
<tr>
<th>District Health Board</th>
<th>Number of assessments</th>
<th>Percentage of assessments %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canterbury</td>
<td>97</td>
<td>34.3</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>49</td>
<td>17.3</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>36</td>
<td>12.7</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>30</td>
<td>10.6</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>24</td>
<td>8.5</td>
</tr>
<tr>
<td>MidCentral</td>
<td>21</td>
<td>7.4</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>14</td>
<td>4.9</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>10</td>
<td>3.5</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>283</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

A total of 283 section 10 assessments were completed in the nine audited DHBs over the audit period.

The majority of files (233 or 82.3%) contained enough documentary evidence for the audit. Fifty assessments required clarification with the assessing medical practitioner over the phone. In three cases no information regarding consultation was available because the nature of the contact was not documented and the doctor had left the country (n = 1) or the doctor was on long-term leave (n = 2). Only partial information regarding consultation was available on five files. In these cases the medical practitioner declined to comment (n = 2), was unable to recall (n = 1) or was unsure (n = 2). In each of these cases it was assumed that no family/whānau consultation had occurred.

The file audit (including contact with the assessing medical practitioner) resulted in a complete set of data gathered on 275 out of 283 (97.2%) files. A total of 112 medical practitioners were
included in the audit. The average number of assessments for each medical practitioner was 2.5 (ranging from 1 to 11).

The total of number assessments nationally in November to December 2004 was 1030. The audit sample of 283 represented 27.5% of the total number of assessments.

**Demography of sample**

The total number of individuals seen was 270 with 11 individuals (two male and nine female) seen on two occasions and one (female) seen on three occasions.

The gender split of the sample (46% male, 54% female), and age distribution (see Figure 1) were not statistically different from the MHINC dataset over the same time period. However there were fewer Maori (n = 52) and Pacific people (n = 6) included in the audit than would be representative of the country as a whole. This reflects the ethnicity mix of areas surveyed.
Family/whānau consultation

Figure 1 shows the breakdown of the results of family/whānau consultation.

**Figure 1: Family/whānau consultation**

- 283 assessments
  - 93 (32.8%): No consultation
  - 187 (66.1%): Consultation happened
  - 3 (1.1%): No information

**Reason for no consultation**
- 70 (75.3%): Not reasonably practicable
- 6 (6.5%): Not in best interests
- 17 (18.2%): Other

**Reason for not reasonably practicable**
- 31 (44.3%): No known family
- 32 (45.7%): Family unavailable
- 1 (1.4%): Contact not wanted
- 6 (8.6%): Refused to give details

Family/whānau consultation occurred in 187 (66.1%) of the 283 assessments audited and did not occur in 93 assessments (32.8%).

The assessing medical practitioner undertook the family/whānau consultation in 124 (43.8%) assessments, while other staff (eg, nurses or section 8B medical practitioners) undertook the consultation in 37 (13.1%) assessments. In 26 (9.2%) assessments it was not recorded who did the consultation (22 of these assessments were from one DHB that did not record this information routinely).

In one consultation the family/whānau was contacted, but they did not have contact with the proposed patient, were not aware that the proposed patient was even alive, and did not want contact with the proposed patient.
In 70 assessments consultation was judged ‘not reasonably practicable’, when no family/whānau was identified or known \((n = 31)\), family/whānau were identified but were unavailable \((n = 32)\), family/whānau were identified but did not want contact \((n = 1)\) or the patient was refusing to give family/whānau contact details \((n = 6)\).

On 6 occasions consultation was not in the best interests of the proposed patient as per the section 7A(3)(b) exclusion. In each case there was evidence the proposed patient had been consulted regarding this as required by section 7A(4).

The reasons for assessments without consultation are outlined in Table 2.

<table>
<thead>
<tr>
<th>Exclusion</th>
<th>Justification</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 7A(3)(a)</td>
<td>‘Not reasonably practicable’</td>
<td>70</td>
</tr>
<tr>
<td>Section 7A(3)(b)</td>
<td>‘Not in best interests’</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>Middle of the night/after hours</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Instructions given to consult later</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Not rung because family had initiated Mental Health Act process</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Well-known inpatient, repeatedly assessed under Mental Health Act</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Patient already inpatient, family had been previously ‘happy’ about admission</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Assessing practitioner refused to comment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Assessing practitioner unsure or could not recall</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>93</td>
</tr>
</tbody>
</table>

The sample was reviewed comparing the assessments of Māori and Pacific patients \((n = 58)\) with those of non-Māori non-Pacific patients \((n = 212)\). These groups did not differ significantly by age or gender distribution. Patterns of family/whānau consultation between the two groups were not significantly different.

**Discussion**

The audit appears to have captured a sample that is representative of the whole country in terms of gender and age distributions.

The audit sample under-represented Māori and Pacific peoples, although it had a sizeable representation of Māori \((19.3\%)\). This finding is likely to be because no data from DHBs from the upper North Island was available.

Overall, the audit demonstrated broad compliance with the requirements of section 7A in at least 93\% \((263\text{ out of } 283)\) of cases.

An outstanding issue is whether the assessing medical practitioner or responsible clinician must be the person who undertakes the consultation.
A few other practices warrant further scrutiny such as a lack of consultation with a family/whānau if it would occur after hours, where instructions are given for consultation to occur later. These practices appear inconsistent with the legislation.

It is important to acknowledge that this audit is restricted to high-level information regarding consultation, and is reliant on the self-report of clinicians conducting those assessments. While we have no reason to doubt the accuracy of the data, ‘consultation’ ranges from merely ‘informing’ at one end of the spectrum to meaningfully ‘including’ at the other.

Clinical situations also vary, from those where the views of the family/whānau are essential to explore all treatment options to those where clinical findings are so overwhelming the nature of family/whānau consultation will fall towards the informing end of the consultative spectrum. That said, there is always a role for meaningful consultation.

It is hypothesised that the recording of family/whānau consultation, on a ‘clinical report form’ to the DAMHS or similar, served as a reminder to clinicians of the existence of the legal requirements and thereby increased the rate of family/whānau consultation in areas with such forms. No data are available from DHBs without a similar reminder on this form for comparison. If this is a relevant factor in the amount and nature of consultation the recent development of a ‘clinical report form’ for use nationwide will be a useful mechanism to prompt clinicians undertaking MHA assessments.

The sample excluded assessments under sections 10 and 11 when a finding of mental disorder was not found. Ideally all such assessments would have been included as a measure of how well section 7A was followed when proposed patients did not become formally committed patients. However, this information was inconsistently recorded at the service level, so was unavailable for the audit.

This audit may serve as a baseline for comparing the level of family/whānau consultation in the future, particularly if the legislation or guidelines change.
Survey of Responsible Clinicians

Introduction

In the absence of data about practice before the 1999 amendment to include section 7A in the MHA, a questionnaire-based survey of current responsible clinicians was undertaken to explore possible changes in practice since the amendment. In addition, the survey was used to give an indication of responsible clinicians’ training experiences, exposure to and views about the guidance material, and understanding of section 7A.

Methodology of survey

An email questionnaire was developed (and is reproduced in Appendix E).

The questionnaire’s development included a pilot survey of 18 responsible clinicians in Wellington, following which the questionnaire was amended.

All questionnaires collected background information regarding the experience and training of responsible clinicians in New Zealand.

Responsible clinicians’ views were sought regarding their exposure to and views on the:

- Ministry of Health guidelines (Ministry of Health 2000)
- Involving Families guidance notes (RANZCP 2000)
- Health Research Council and Ministry of Health workshop on family/whānau involvement for the mental health workforce.

Responsible clinicians were surveyed about whether their practices had changed following the introduction of section 7A and their knowledge of section 7A.

Each DAMHS supplied the Ministry of Health with a list of all current responsible clinicians and their email addresses. Responsible clinicians who were not contactable by email were not included in the survey.

An estimated 70% of responsible clinicians were contacted.

Responses were kept anonymous. Those who did not respond to the first email within two weeks received a reminder, which was sent again if no response was received after four weeks.

Results of survey

Response rate

The DAMHSs identified 395 responsible clinicians. Of this total 103 were unable to take part in the survey because no email address was available for them or the email address supplied resulted in mail being returned as ‘address unknown’. A total of 167 completed responses were received, giving a response rate of 57.2%.
Responses were received from 19 of the 21 DHBs. Two DHBs did not have operational email systems, which accounted for 12 of the unavailable responsible clinicians. The response rate in one DHB (82%) was higher than that in the rest of the country (52.1%) and can be attributed to the pilot survey being run in that area.

**Occupation**

The majority of the respondents were consultant psychiatrists (n = 127), representing 76.0% of replies. The remaining responses were from psychiatric registrars (8.4%), medical officers (11.4%), general practitioners (1.2%), nurses (1.2%) and psychologists (1.8%). It is not known whether this is representative of the distribution of professional groups performing the role of responsible clinician as no data are available.

**Country of mental health training**

The country of training in mental health of the respondents is outlined in Table 3. In the two cases where two countries were identified, both were recorded. More than half (55.1%) the responsible clinicians received their mental health training in New Zealand.

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>92</td>
<td>55.1</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>36</td>
<td>21.6</td>
</tr>
<tr>
<td>South Africa</td>
<td>12</td>
<td>7.2</td>
</tr>
<tr>
<td>Europe excluding the United Kingdom</td>
<td>7</td>
<td>4.2</td>
</tr>
<tr>
<td>India</td>
<td>7</td>
<td>4.2</td>
</tr>
<tr>
<td>United States</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>Australia</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>Canada</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Singapore</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>167</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**Familiarity with section 7A**

Overall, 91.6% of responsible clinicians believed they were familiar with the requirements of section 7A and 88.6% were aware that family/whānau consultation was mandatory by law subject to specific exceptions.

**Adequacy of section 7A**

Eighty percent of clinicians believed the current MHA requirements allowed for adequate inclusion of family/whānau.

Twelve percent did not believe the requirements were adequate, 4.2% (n = 7) were unsure or did not know and 3.6% (n = 6) did not comment.
Responsible clinicians held a range of views about section 7A, including the view that the role of the family was exaggerated, was out of proportion and impinged on individuals’ privacy rights to the view that the section was poorly followed and required strengthening to ensure family involvement.

Many responsible clinicians commented on the difficulty in legislating for what was, in their view, essentially good clinical practice. They felt that accounting for all cultural, individual, family/whānau and clinical needs was impossible in legislation.

Responsible clinicians who identified themselves as from child and adolescent or psychogeriatric subspecialties said family/whānau consultation was intrinsic to their practice. Responsible clinicians identified a range of difficulties they experienced in specific clinical situations.

**Changes in practice since 1999**

A majority of responsible clinicians (55.7%) did not believe their practices had altered since the introduction of section 7A.

A smaller group (40.8%) of responsible clinicians stated that their consultation process at section 10 (preliminary assessment) differed from that at other stages.

Frequent comments from responsible clinicians included that family were more often involved earlier, they were more rigorous in consulting with families, consultation was done by phone rather than face-to-face, and consultation was more focused on safety issues initially.

Of the 167 respondents, 95 (56.9%) were working in New Zealand before section 7A. Of these 54.7% believed their practices had changed since section 7A. The majority of these clinicians commented that they consulted with family more since the section was introduced.

Forty-three percent of responsible clinicians did not believe their practices had changed.

**Training**

The survey asked responsible clinicians whether they had:

- received training in the MHA
- received training in the 1999 amendment
- read the Ministry of Health guidelines
- read the *Involving Families* guidance notes
- attended the Ministry of Health and Health Research Council workshop on family/whānau consultation.

The results are outlined in Table 4.
Clinicians were also asked their views about the guidelines and workshop. They reported that they felt the quality of training in the MHA and its amendment was variable. Clinicians stated they had to request training themselves and it had been of inconsistent or ad hoc quality.

The Ministry of Health guidelines and RANZCP guidance notes were generally well regarded and described as clear, appropriate and comprehensive. However, there was some comment that they were idealistic, time consuming and unmanageable. Some clinicians reported that the guidance notes, although useful, were under-used or not widely known about.

There were several specific questions about how to deal with certain situations and clinicians said that they would like guidelines to be more practically focused.

No qualitative statements were made about the workshop, although some clinicians noted they had not heard of it or would like to attend.

The views and experiences of overseas-trained clinicians were compared with those of New Zealand-trained clinicians. Those who had been practising as responsible clinicians in New Zealand before the amendment were also compared with clinicians who had become responsible clinicians after the amendment. Unless otherwise stated, the differences discussed below were statistically significant.

Clinicians who had been practised as responsible clinicians before the amendment were more familiar with the requirements to consult (96.9% compared with 86.6%) or the RANZCP guidance notes (40.8% compared with 20.3%).

Clinicians who were overseas trained and had become responsible clinicians after the amendment had the lowest rate of training in the MHA (60.6% compared with 90.0%) and were less likely to be aware of the mandatory requirement for family/whānau consultation (75.8% compared with 90.8%).

Clinicians who had been responsible clinicians before the amendment were more familiar with the requirements to consult (96.9% compared with 86.6%) or the RANZCP guidance notes (40.8% compared with 20.3%).

### Table 4: Training experiences of responsible clinicians

<table>
<thead>
<tr>
<th>Training experience</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended Mental Health (Compulsory Assessment and Treatment) Act 1992 training</td>
<td>137</td>
<td>82.0</td>
</tr>
<tr>
<td>Attended 1999 amendment Act training</td>
<td>93</td>
<td>55.7</td>
</tr>
<tr>
<td>Read Ministry of Health guidelines</td>
<td>73</td>
<td>43.7</td>
</tr>
<tr>
<td>Read Royal Australian and New Zealand College of Psychiatrists <em>Involving Families</em> guidance notes</td>
<td>54</td>
<td>32.3</td>
</tr>
<tr>
<td>Attended Ministry of Health/Health Research Council workshop</td>
<td>4</td>
<td>2.4</td>
</tr>
</tbody>
</table>
Clinician’s views on whether the current requirements for family/whānau consultation were adequate were not significantly different across the groups.

No further analysis was completed on the workshop or the background of the responsible clinician (eg, nursing compared with medical staff) because of the small numbers involved.

**Discussion**

The views of about one-third of all responsible clinicians in New Zealand were gained in relation to issues relevant to family/whānau consultation. The sample is likely to be representative of the entire group of clinicians and was of sufficient size to encompass a significant number of views and experiences.

Generally it was considered that familiarity with the Ministry of Health’s guidelines and RANZCP guidance notes (both under 50%) was poor and that problems with distribution, availability and time were the likely reasons for this. It is recommended that all responsible clinicians have their attention drawn to the appropriate resources and that family/whānau consultation training is extended.

Differences in training experiences about the MHA appear to relate, in part, to where the clinician trained in mental health. The low rates of exposure to resources by overseas-trained clinicians who had become responsible clinicians after the amendment could reflect their relatively recent arrival in the country. Notably the New Zealand-trained clinicians who had become responsible clinicians after the amendment were very aware of the mandatory requirement to consult although had not had significantly more formal training or exposure to guidelines than their overseas counterparts. There is no objective data about the practice of these clinicians. However, the results do identify this group of clinicians as having less exposure to the MHA and less training and exposure to guidance material, and leads further to the recommendations about improving access to training and guidance material.

Recently arrived overseas-trained psychiatrists should be exposed to a training package that includes expectations around family/whānau consultation in care planning. This needs to be brought to the attention of each DAMHS.

When a clinician is approved to be a ‘responsible clinician’ the clinician should have a sound understanding of the workings of the MHA. Therefore, it is important to ensure MHA training has occurred before this point, regardless of a clinician’s country of training.

Clinicians stated that family/whānau consultation was a variable experience at different stages of the MHA process. It is likely this range of views reflects the nature of individual cases and highlights the difficulty in mandating specific processes when there are common exceptions and multiple variations.
Significant positive points from the survey were that, as a group, responsible clinicians were well aware of both the clinical and legal significance of consultation with family/whānau. Several responsible clinicians believed they were more rigorous in ensuring family/whānau consultation happened after the 1999 amendment.

Of note, responsible clinicians did say they sought guidance on specific issues, for example, when a family and patient were in conflict about consultation.
Experiences and Views of Interested Groups and Individuals

Methodology
The views and experience of a range of groups and individuals were sought as part of this review. All professional groups, family groups and service user networks identified as potential interested parties, were invited to provide their views and to circulate the invitation to others who may be interested. (See Appendix F for the list of individuals and organisations from whom submissions were received.)

In addition to a general response, comment was invited on issues specific to section 7A, including people’s awareness of changes in practice since the amendment, views on the exclusions to mandatory family/whānau consultation, and views about the Ministry of Health-published guidelines (Ministry of Health 2000; RANZCP 2000).

Submissions received
Thirty-one submissions were received.

Submissions from families/whānau and related groups
The largest number of submissions came from families, groups representing families, or family/whānau advisors or facilitators.

Broadly this group was the most concerned that the current legislation, guidelines and training did not facilitate enough consultation with families, families did not feel heard, and families felt disempowered.

Comments were made that section 7A had not had a significant effect on family inclusion or consultation, although some family workers said families in their area did feel supported and consulted. Family advisors stated they were still aware of instances when family/whānau consultation was poorly or not done. However, there were also comments that section 7A, if properly followed, could provide an appropriate level of family/whānau involvement and consultation and that the main issues were poor adherence to the legislation, inadequate clinician training and lack of awareness by families of their rights and service obligations (such as attending court hearings).

Proposed strategies included the mandatory notification of parents or caregivers of any patient with depression, the removal of all exclusions to section 7A consultation, or introduction of a right for families/whānau to appeal any decision not to consult before some authority.

Concerns were raised about the medical practitioner or responsible clinician making the final decision about what was reasonably practicable or in the patient’s best interests.

It was also noted that deciding who is family/whānau can be a sensitive issue, especially when family members disagree (eg, a spouse and a parent of a patient).
There was concern about an unwell patient’s ability to decide who should be consulted. One submission suggested clinicians should be expected to release information without the patient’s knowledge, as having to discuss the release of information with the patient was an impediment to clinicians consulting families.

Several submissions were concerned that there was a lack of accountability for any lack of consultation, especially when it was associated with a poor outcome.

Submissions called for more information to be given routinely to families/whānau about mental illness, MHA processes and their rights.

Similarly there were concerns that the Privacy Act 1993 conflicted clinicians and was overemphasised, and that definitions of ‘reasonably practicable’ and ‘best interests’ were not specific enough or available.

The importance of training clinicians about New Zealand legislation and culture was highlighted.

Many submissions noted that consultation was an ongoing process and that a patient’s wishes about who should be involved can change.

There was an expectation that consultation would be direct and with a member of the treating team involved in decision making, such as the responsible clinician.

**Submissions from other groups/individuals**

Professional bodies and individuals (eg, the Royal Australian College of Psychiatrists, the Health and Disability Commissioner, the Mental Health Commission, district inspectors and the New Zealand College of Mental Health Nurses) as well as service users and service user groups, generally commented that the legislation allowed for appropriate consultation. Family/whānau consultation was recognised as part of good clinical practice and was not just applicable to people subject to the MHA.

Concerns were expressed that changes and recommendations should be based on sound research evidence rather than anecdote and opinion, and that ‘fine tuning’ legislation would be unlikely to effect significant changes. It was repeatedly noted that clinical practice should lead legislation and there was a risk of over-mandated practices not allowing for the range of clinical and individual circumstances.

A wide range of experiences regarding how fully section 7A was used and followed were given.

It was noted that complaints to the Health and Disability Commissioner had identified examples of inadequate family consultation, although it was not possible to discern any trend in this regard.

It was noted that clinicians and families often had different perspectives about consultation.

Some submissions thought family/whānau involvement was improving.
The Ministry of Health’s guidelines were generally thought to be appropriate, helpful and comprehensive, although it was suggested that they were too long and busy clinicians lacked the time to read them. However, some submissions recommended the guidelines needed more depth and practical guidance. Various suggestions were made about training and the format and distribution of the guidelines.

Similarly, the RANZCP guidance notes were often referred to as helpful and useful for clinical practice.

Issues about advance directives, other clinicians consulting families and the content of the guidelines were also raised.

**Summary**

The consensus was that section 7A allows for adequate consultation.

A range of views and experiences were received. Families and related groups were the least satisfied with current practice as they perceived it. At times families continue to feel unheard and dismissed.

Issues pertaining to clinicians adhering to the legislation and using published material such as guidelines were thought to be important. A range of suggestions were made about possible changes, including:

- mandatory family notification for all cases
- no exceptions to family/whānau consultation
- an appeal process for families not consulted
- improved training for clinicians on family/whānau consultation
- greater exposure to and availability of resources including guidelines
- more information provided to family/whānau
- shorter, more concise guidelines
- a more detailed and practical focus in guidelines.
Review of Section 7A’s Application, particularly Consultation with Principal Caregivers

Section 7A’s application has been considered in light of current literature, overseas legislation, the WHO legislation checklist, an audit of clinical practice, a survey of responsible clinicians, and submissions from interested parties. This has demonstrated:

- family/whānau play important roles in the mental health of their family members
- legislative procedures for commitment are a source of significant burden and concern for family/whānau
- section 7A, in comparison with overseas legislation regarding family involvement and using the WHO checklist, represents an advanced position, although it does not directly consider a patient’s capacity to consent to family/whānau consultation
- section 7A is broadly complied with during early MHA processes, but some current practice potentially falls outside the legislation
- the legal requirement to consult has contributed clinicians becoming more assertive in consulting with families/whānau (in the view of responsible clinicians)
- a low level of exposure to training about the MHA, Ministry of Health guidelines (Ministry of Health 2000) and RANZCP guidance notes (RANZCP 2000)
- a consensus, across a range of relevant groups and individuals, that section 7A allows for adequate family/whānau consultation, which is tempered with concerns about training experiences, exposure to and the usefulness of guidelines, issues arising in distinctions between ‘family/whānau’ and ‘caregiver’, and how well section 7A is followed.

The following issues therefore require further discussion:

- amendment to section 7A
- concepts of ‘reasonably practicable’ and ‘best interests’
- practices outside the MHA
- training experiences
- exposure to guidelines and other resources
- a new clinical report form
- consultation with principal caregivers
- family/whānau attendance at court hearings.

Amendment to section 7A

Some submissions suggested changes to section 7A, although the consensus was that if followed appropriately the section allowed for adequate consultation with family/whānau.

Some submissions, most notably from families or family groups, wanted fewer exceptions to mandatory family/whānau consultation and the clinician to be required to consult regardless of a patient’s wishes.
As noted in the guidelines, if consulting with family/whānau is not in the patient’s ‘best interests’, such as may apply if a competent patient does not consent to family/whānau consultation, this does not preclude the clinician seeking information from family/whānau or the family/whānau providing further information to the clinician. The guidelines further state that family/whānau may be given information about providing ongoing care or if it will prevent a serious threat to the life or health of the patient or family/whānau members.

Therefore, in all eventualities, the current legislation and guidelines allow for the family/whānau viewpoint to be considered by the treating team at the very least and for important information to go to the family/whānau.

The exceptions cater for the frequent times (as demonstrated in the audit) when family/whānau consultation is not possible under the ‘reasonably practicable’ exception. The ‘best interests’ exclusion enables the principle of patient autonomy to be maintained. A major shift away from patient autonomy would be required to remove this second exclusion.

The issue of a patient’s competence is not considered directly under section 7A. However, the guidelines do address this issue when a clinician is considering who is the family/whānau or is considering not consulting following a patient’s wishes.

On the basis of a comparison with other legislation and the WHO checklist it appears that section 7A and the related guidelines are an advanced position, which balances the sometimes competing rights of patients and family/whānau clearly.

Therefore, no change to section 7A is recommended. It is the Ministry of Health’s view that issues about training and exposure to resources are more relevant and more likely to effect improvements in mental health services involving families/whānau than simply a reworking of the current legislation.

**Concepts of ‘reasonably practicable’ and ‘best interests’**

Responses from responsible clinicians and others queried the meaning of ‘reasonably practicable’ and ‘best interests’. The Ministry of Health guidelines specifically address these two concepts and give examples, which should be highlighted to clinicians.

The concept of ‘reasonably practicable’ was considered in the High Court of England and Wales (*ER (on the application of) v Bristol City Council* EWHC74 URL: http://www.bailii.org/ew/cases/EWHC/Admin/2005/74.html (accessed 28 July 2005)). In this jurisdiction, an application for compulsion requires an approved social worker to first consult with the person’s nearest relative, unless such consultation is considered not reasonably practicable or would involve unreasonable delay. In considering the term ‘practicable’ it was stated:
the term practicable is an ordinary English word of great flexibility: it takes its meaning from its context. But, whenever used, it is a call for the exercise of common sense, a warning that sound judgement will be impossible without compromise. Sometimes the context contemplates a situation rarely to be achieved, though much desired. Sometimes, as is submitted in the present case, what context requires may have been possible, but may not for some reason have been ‘practicable’. Whatever its context, the quality of the word is that there are circumstances in which we must be content with less than 100 percent: and it calls for judgement to determine how much less.

The principles behind this description should be added to the Ministry of Health’s guidelines.

**Practices outside the Ministry of Health guidelines**

The audit identified a small number of practices that required further consideration and a legal opinion was sought. These practices were:

- delegating to another staff member the requirement to consult
- postponing consultation with or without instructions to consult later
- not consulting on the ground the family has initiated the assessment
- not consulting on the ground the family was previously ‘happy’ about the person’s admission
- not consulting on the ground the inpatient is well known and the family has been consulted about other assessments.

**Delegating the requirement to consult**

The audit identified that when family/whānau consultation did occur about one-quarter of the time it was undertaken by someone other than the assessing medical practitioner.

For several legal and clinical reasons this is undesirable. Section 7A clearly places the onus of consultation on the assessing medical practitioner or responsible clinician and there is no mechanism for delegating this. The legislative intent is to put the practitioner in direct communication with the family/whānau and delegating this to someone, who may be less well qualified and have less authority for making decisions (such as certifying a person under the MHA) impedes this. Furthermore consultation is not solely about listening, but involves a dialogue between key parties. Delegating this function to a third party introduces a risk of miscommunication. The expectation that the practitioner excises his or her judgement, on reasonable grounds, about what is reasonably practicable or in the patient’s best interests further implies that it is the practitioner, rather than a third party, who should be consulting the family.

While it could be argued that resource constraints (eg, lack of clinician time) sometimes leads to consultation being impracticable, no leeway in this regard is allowed for in the legislation. If there were an intent to allow delegation, so no issue of practicability arose on the practitioner’s part, this exception would be phrased differently (eg, ‘whether the family/whānau can be contacted for consultation’).

If delegating were possible, doing so properly would require a record of how it was completed and what information was exchanged. This would be time-consuming and far less efficient that direct communication.
It might be that another member of the clinical team has a more enduring or established relationship with a family/whānau. The MHA does not prohibit other people from being involved in the consultation and these clinical staff may have valuable roles and knowledge in facilitating the consultation.

Nevertheless there is strong justification that, in its current form, section 7A does not allow for delegation of the responsibility to consult with family/whānau.

Delegating the requirement to consult should be covered in the Ministry of Health’s guidelines.

**Postponing consultation with or without instructions to consult later**

The Ministry of Health does not consider delaying consultation, because of the time of day, or leaving instructions to consult later a desirable practice. For consultation to be meaningful it has to occur before key decisions are made. An instruction to consult after a decision has been made reduces the consultation to a process of informing.

It could be argued that consultation after hours is not reasonably practicable, so is subject to exclusion. However, should an assessment under the MHA occur after hours it would be an urgent assessment and family/whānau consultation may be highly relevant to immediate safety and risk issues. A clinical parallel is a family member admitted to hospital for a serious physical illness, in which case most families/whānau would desire to be, at the very least, notified as soon as possible.

The Ministry of Health’s view is that in the majority of instances, delaying consultation on the grounds of the assessment happening outside normal working hours is not good practice. Consultation does not have to happen face to face and it is envisaged that after hours consultation may more commonly happen over the phone.

Postponing consultation should be covered in the Ministry of Health’s guidelines.

**Not consulting because family initiated the assessment or was previously consulted**

The Ministry of Health does not support the practices of not consulting on the grounds the family had initiated the assessment or had been consulted during other assessments or at the time of admission.

The importance of consultation being a two-way process and an ongoing process, in which parties may change their views or circumstances may change, is at variance with these examples. (These examples occurred only once each in the audit.)

This example should be covered in the Ministry of Health’s guidelines.

**Training experiences**

The survey of responsible clinicians identified their limited exposure to training about the MHA. Training was often described as of an informal or ad hoc nature.
Responsible clinicians had had almost no exposure to the Ministry of Health and Health Research Council MHA workshop.

Given the significance of a range of legal MHA matters it is worth considering how training on these matters is best done, whether through professional bodies during basic training (eg, by the RANZCP when training psychiatrists) or as competencies through each DAMHS at DHB level.

Particular attention in training should be paid to what consultation (as opposed to notification) involves and the definitions of such expressions as ‘reasonably practicable’ and ‘best interests’.

In 2004 the Health Research Council, in partnership with the Ministry of Health, completed training on family/whānau involvement for trainers in each region, as part of the Mental Health Workforce Developmental Programme (MHWDP). Trainers in each region have the capability to provide a course for responsible clinicians. The programme they have been trained to deliver, includes a wider range of topics about family/whānau, including the relevant legislation and could be modified to be suitable for responsible clinicians.

The Ministry of Health recommends that in relation to family/whānau consultation responsible clinicians are given the opportunity to attend the MHWDP course.

**Exposure to Ministry of Health guidelines and other resources**

The relatively poor exposure to the Ministry of Health guidelines and RANZCP guidance notes suggests action should be directed to advertising the existence of this material and redistributing it. Both documents are also available through the Ministry of Health website (http://www.moh.govt.nz) or the RANZCP website (http://www.ranzcp.org/).

It is the Ministry of Health’s view that a strategy for increasing exposure to the guidelines and other resources is warranted.

**New clinical report form**

The MHA requires a medical practitioner to send the DAMHS ‘full particulars of the reasons for his or her opinion of the (proposed) patient’s condition’ at a number of junctures in the MHA process.

The clinical file audit found evidence of variable practices around the country for the recording of ‘full particulars’. Information regarding family/whānau consultation was recorded routinely on only some of these forms.

A new clinical report form has been developed for use nationwide. Input into its development was sought from the DAMHS and the principal family court judge. The new form includes a section on family/whānau consultation and requires a justification if family/whānau consultation does not occur.

It is possible the new form will prompt clinicians during MHA processes and promote consistent practice nationally. The form could be audited in a similar manner to the audit in this review to establish changes in clinical practice and to compare practices around the country.
Consultation with ‘principal caregiver’

Section 1.4 of the Ministry of Health guidelines discusses the definition of ‘principal caregiver’ and is reproduced in Appendix G.

The review of overseas legislation showed that many different terms are used to cover the broad concept of ‘family/whānau’. In the MHA a key term is ‘principal caregiver’, which is defined, in relation to any patient, 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’. The term ‘welfare guardian’ is also used and means a person so appointed under the Protection of Personal and Property Rights Act 1988.

In MHA processes, the principal caregiver and welfare guardian (if one is appointed) receive copies of assessment certificates by the responsible clinician, and review tribunal findings.

The principal caregiver will often be a member of the person’s family/whānau. This means a family/whānau member will commonly be aware of processes occurring under the MHA, but this does not satisfy the statutory requirement for consultation. Sometimes the principal caregiver may disagree with other significant family/whānau members. However, in practice it does not seem feasible or appropriate to send certificates to every family/whānau member. More than one principal caregiver may be appointed.

Section 7A does not mention the principal caregiver. However, it is clear by the definition of family/whānau in the Ministry of Health guidelines that a principal caregiver would be included as family/whānau. Therefore, in addition to being provided statutory notifications, a principal caregiver, for the purposes of section 7A, should be considered as family/whānau, so consultation with the principal caregiver is mandated and the guidelines should note this.

It is not clear how broad the family/whānau group with which consultation must occur is and whether consultation with only the principal caregiver is sufficient to met the section 7A requirements. The Ministry of Health guidelines state that the patient decides who are family/whānau and principal caregiver in the first instance, which can give an indication of how wide consultation should be.

Family/whānau attendance at court hearings

The literature review noted that family/whānau can have a significant impact during court hearings and submissions reported that families were often unaware of their rights, including opportunities to attend hearings. These issues can be addressed by developing additional pathways by which families/whānau are made aware of the opportunity to attend hearings, whether that be through family advisors or care managers or during consultation with the responsible clinician.

Family members may attend a hearing to decide on an application for a compulsory treatment order (section 24 of the MHA). This may be as a person nominated by the patient, as a principal caregiver or welfare guardian, or be any other person the judge sees fit to include. The court may also exclude any person from proceedings. The judge may consult any other people as he
or she sees fit when considering an application for a compulsory treatment order or a section 16 ‘review of patient’s condition’.
Review of Ministry of Health Guidelines to Ensure Adequate Information about Principal Caregiver’s Role and for Caregivers

Chapter 4 of the Ministry of Health guidelines (Ministry of Health 2000) is about the requirement to consult with family/whānau. It is reproduced in Appendix H.

Overview

The submissions and survey of responsible clinicians indicated the Ministry of Health guidelines were generally considered appropriate, helpful and comprehensive. However, it was also suggested that they were too long and busy clinicians had insufficient time to digest them.

The majority of specific questions raised in submissions are already covered in the guidelines.

The structure of ‘how to consult’ and ‘when to consult’ gave the document usability that was acknowledged by some clinicians.

Questions were asked about the definitions of the terms ‘best interests’, ‘reasonable grounds’ and ‘reasonably practicable’, so they need to remain foremost in the guidelines.

Some clinicians regarded the guidelines as overly idealistic and unworkable, consuming too much time. The Ministry of Health rejects this view.

Revision of guidelines

On the basis of this review it is recommended that the guidelines be revised to clarify or provide further guidance on the following.

- The definitions of ‘consultation’, ‘reasonable grounds’, ‘reasonably practicable’ and ‘best interests’.
- Assessments occurring late at night or after hours.
- Consultation by people other than the responsible clinician.
- When to consult, including consultation at the section 12 stage.
- Different consultation mechanisms (e.g., in person or over the phone).
- Attendance by family/whānau at court hearings.
- Inclusion of the ‘principal caregiver’ as a member of the family/whānau.
- Issues relating to guardianship and the principal caregiver.
- Information that must be sent to the family/whānau, principal caregivers and guardians.
Cultural issues

Section 4.4 of the Ministry of Health guidelines is entitled ‘Māori’ and gives specific attention to family/whānau involvement for Māori and Pacific peoples (see Appendix H).

The clinical audit identified no statistically significant difference in practice between consultation with Māori and Pacific family/whānau and with other family/whānau in the early stages of MHA processes.

Two comments were specific to Māori and the different definition of whānau in the survey of responsible clinicians. No submissions from organisations that identified themselves as specifically Māori organisations were received.

Distribution of guidelines

The survey of responsible clinicians identified a low rate of exposure to the Ministry of Health guidelines and other resources. It is recommended that a distribution strategy be developed to address this problem. This could be in conjunction with a MHWDP workshop.

Additionally, clinicians on being appointed as responsible clinicians should be routinely supplied with the guidelines from their DAMHS.
Recommendations

The recommendations arising from this review are as follows.

Legislation
1 Section 7A of the MHA is not amended.

Revisions to guidelines
2 The Ministry of Health guidelines are revised to:
   • further define ‘consultation’, ‘reasonably practicable’ and ‘best interests’
   • provide practical examples of the defined terms
   • address consultation for assessments late at night or after hours
   • address consultation by people other than the responsible clinician
   • clarify when consultation should occur, including consultation at the section 12 stage
   • discuss the different mechanisms for consultation (eg, in person or on the phone)
   • discuss family/whānau attendance at court hearings
   • include the principal caregiver as a family/whānau member
   • address guardianship and principal caregiver issues.

Distribution of guidelines
3 A strategy for releasing the revised Ministry of Health guidelines is developed.
4 Other resources (eg, guidance notes (RANZCP 2000)) are redistributed to responsible clinicians.

Training
5 Responsible clinicians are given opportunities to attend an MHWDP workshop on involving family/whānau in MHA processes.
6 Clinicians are given more training and better access to resources about the MHA, particularly clinicians:
   • arriving from overseas
   • being appointed as responsible clinicians.

Information
7 The new clinical report form is used consistently throughout the country.
8 More information is given to family/whānau and principal caregivers about, for example:
   • the provision for family/whānau consultation under section 7A
   • opportunities to attend court hearings.
Summary

This review has considered the application of section 7A of the MHA and then reviewed the guidelines published by the Ministry of Health (Ministry of Health 2000; RANZCP 2000). This included a literature and legislation review, an audit of current clinical practice, and a survey of responsible clinicians and considered submissions from a range of organisations and individuals.

No changes to section 7A are recommended.

Little evidence exists about the effects of involving families in a family member’s compulsory commitment and treatment exists. Section 7A mandates for consultation with family/whānau, but allows exemptions to account for the wide and common range of circumstances when family/whānau consultation is not practicable, as identified in the audit. The legislation reflects an advanced position in respect of including family/whānau in compulsory care compared with much overseas legislation and also protects the fundamental rights of patients and proposed patients. The survey indicated that the introduction of section 7A made clinicians more aware of and attentive to involving families.

The legislation requires clinicians to apply the guidelines issued under section 130. Changes to the guidelines are suggested to clarify the issues that have arisen in this review. In particular, the expectation that the responsible clinician or assessing medical practitioner personally consults with family/whānau needs to be highlighted.

The survey identify adequate training and exposure to the guidelines, so changes to training experiences and increasing clinician exposure to the guidelines are recommended. Training experiences should be aligned with the sector’s accreditation processes for a person to become a responsible clinician. The MHWDP has a workshop focused on family/whānau involvement, which is recommended as a useful training experience for responsible clinicians.

The new clinical report form, which includes a section on family/whānau consultation, will promote consistent consultation and recording practices nationally.

Mechanisms to facilitate the involvement of families/whānau at court hearings and to improve access to information for family/whānau warrant development.

Involvement of the family/whānau is an important principle regardless of a patient’s legal status under the MHA. Promoting good clinical practice rather than legal requirements that are relevant for only some mental health service users (and only for a certain period) is likely to have greatest benefits for mental health services users, including those receiving compulsory assessment and treatment. The RANZCP guidelines continue to be a valuable resource for all mental health services providers.

Additional mechanisms, guidelines and codes are in place that contribute to this area, such as family advisors in DHBs, the SF Code of Family Rights, the Health Information Privacy Code 1994, and the Code of Health and Disability Services Consumers’ Rights 1996. These have not been focused on in this review.
The Mental Health Commission (2004) has reported that consultation with families has improved over recent years. The involvement of family/whānau extends beyond any legislative demands in relation to committed patients and falls within the realms of best clinical practice for all mental health service users. A continued focus on the development of a wider culture of family/whānau consultation that takes into account the circumstances of the clinical situation and an individual’s rights is recommended.
Appendix A: Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992

Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992 states:

Section 7A: Medical practitioner or responsible clinician to consult

(1) In this section, ‘practitioner’ means –
   (a) a medical practitioner conducting an assessment examination of a proposed patient under section 9; and
   (b) a responsible clinician providing an assessment of, or treatment to, a patient.

(2) A practitioner must consult the family or whānau of the proposed patient or patient. This subsection is subject to subsection (3).

(3) Subsection (2) does not apply if the practitioner has reasonable grounds for deciding that consultation –
   (a) is not reasonably practicable; or
   (b) is not in the best interests of the proposed patient or patient.

(4) In deciding whether or not consultation with the family or whānau is in the best interests of a proposed patient or patient the practitioner must consult the proposed patient or patient.

(5) A practitioner must apply any relevant guidelines and standards of care and treatment issued by the Director General of Health under section 130, when –
   (a) deciding when and how to consult the family or whānau, or the proposed patient or patient; and
   (b) deciding whether or not consultation with the family or whānau is reasonably practicable; and
   (c) deciding whether or not consultation with the family or whānau is in the best interests of the proposed patient or patient.
Appendix B: Search Sources and Strategies (as provided by New Zealand Health Technology Assessment)

The following search sources and strategies were used to find publications about involving families of people with mental disorder or substance use disorder in the process of the compulsory assessment and treatment of their family member.

Search sources

Bibliographic databases
Embase: http://www.embase.com/
Social Sciences Citation Index: http://scientific.thomson.com/products/ssci/
Science Citation Index: http://scientific.thomson.com/products/sci/
CINAHL Database: http://www.ovid.com/site/catalog/DataBase/40.jsp?top=2&mid=3&bottom=7&subsection=10
Cochran Controlled Trials Register
Index New Zealand

Review databases
Cochrane Database of Systematic Reviews: http://www.cochrane.org/index0.htm
ACP Journal Club: http://www.acpjc.org/
Database of Abstracts of Reviews of Effects (DARE): http://www.library.ucsf.edu/db/dare.html
NHS Economic Evaluation Database (NHS EED): http://www.york.ac.uk/inst/crd/nhsdhp.htm
Health Technology Assessment

Evidence-based services and websites
TRIP database
ATTRACT (NHS Wales)
ARIF (University of Birmingham)
Bandolier (Oxford)
Canadian Coordinating Office for Health Technology Assessment
United Kingdom National Coordinating Centre for Health Technology Assessment
NMAP/OMNI medical information services
Guidelines websites
Canadian Medical Association
United Kingdom National Electronic Library for Health
US National Guideline Clearinghouse
Scottish Intercollegiate Guidelines Network

Government health agencies
United Kingdom Department of Health
Health Canada
United States Centers for Disease Control
Australian Department of Health and Ageing
Australian National Health and Medical Research Council
United States National Institute of Mental Health
United States Substance Abuse and Mental Health Services Administration

Professional associations
Royal College of Psychiatrists: http://www.rcpsych.ac.uk/
Canadian Psychiatric Association: http://www.cpa-apc.org/
American Psychiatric Association: http://www.psych.org/
Royal Australian and New Zealand College of Psychiatrists: http://www.ranzcp.org/

Other organisations
MIND (United Kingdom) – National Association for Mental Health: www.mind.org.uk
Institute of Mental Health Act Practitioners United Kingdom: http://www.markwalton.net/index.asp
NICE (United Kingdom) – National Institute for Clinical Excellence www.nice.org.uk

Library catalogues
Te Puna – New Zealand bibliographic database
Locatort (United States National Library of Medicine)
World Health Organization Library & Information Service: http://www.who.int/library/
COPAC (United Kingdom academic libraries): http://copac.ac.uk/

Other services
Proquest Journal Service
Google search engine: http://www.google.co.nz/
Search strategies

**Medline/Cochrane Controlled Trials Register**

9 Involuntary Comintement/ (5750)
10 Involuntary comminment.mp (154)
11 compulsory treatment.mp (160)
12 GUARDIANSHIP,LEGAL/ (0)
13 Outpatient commitment.mp (122)
14 Or/1-5 (5894)
15 Exp Family/ (141079)
16 (famil$ or family and carers$).mp (435126)
17 or/7-8 (505693)
18 6 and 9
19 remove duplicates from 10 (315)
20 from 11 keep (selected references) (12)
21 from 11 keep (selected references) (58)
22 from 13 keep 1-58 (58)
23 legal guardians/ or third-party consent/ (6769)
24 6 and 15 (332)
25 remove duplicates from 16 (191)
26 17 not 11 (147)
27 from 18 keep (selected references) (15)
28 THIRD-PARTY CONSENT/ (5242)
29 treatment refusal/ (9365)
30 20 and 21 and 9 (704)
31 familiar.tw (11169)
32 22 not 23
33 remove duplicates from 22 (365)
34 25 not (11 or 18) (356)
35 (mental or psychiatric).tw (153515)
36 26 and 27 (0)
37 COMMITMENT OF MENTALLY ILL/ (5750)
38 29 and 9 (436)
39 remove duplicates from 30 (300)
40 31 not (11 or 18) (0)
41 relative$.mp and (6 or 29) (122)
42 remove duplicates from 33 (94)
43 34 not (11 or 18) (68)
44 from 35 keep (selected references) (7)
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<td>or/7-8 (566636)</td>
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Science and social sciences citation indexes
#1 involuntary treatment OR compulsory treatment
#2 commitment AND (psychiatric OR mental)
#3 relative or relations
#4 family or families
#5 #2 AND #3
#6 #2 AND #4
#& #1 OR #5 OR #6

Other databases
Combinations of the keywords in the strategies above were used to search databases and sources for which strategies are not given.

Note: Search strategies were re-run in July 2005, with relevant articles manually selected.
Appendix C: Key Papers from Literature Review


Lefley HP. 1997. Mandatory treatment from the family’s perspective. *New Directions for Mental Health Services* 75: 7–16.


Appendix D: World Health Organization Checklist on Mental Health Legislation (extract)


**E. Rights of families or other carers**

1) Does the law entitle families or other primary carers to information about the person with a mental disorder (unless the patient refuses the divulging of such information)?

2) Are family members or other primary carers encouraged to become involved in the formulation and implementation of the patient’s individualized treatment plan?

3) Do families of other primary carers have the right to appeal involuntary admission and treatment decisions?

4) Do families or other primary carers have the right to apply for the discharge of mentally ill offenders?

5) Does legislation ensure that family members and other carers are involved in the development of mental health policy, legislation and service planning?
Appendix E: Email Survey of Responsible Clinicians

Email Section 7A Questionnaire for Responsible Clinicians
(Please type in your response or delete incorrect response.)

Question 1  Which District Health Board do you primarily practice in?

Question 2  What is your professional background?  (eg, psychiatrist, registrar, general practitioner, MOSS, nurse, psychologist)

Question 3  In which country did you undertake the majority of your mental health training in?

Question 4  How many years have you practised in mental health (include years of training)?

Question 5  How many years have you practised in New Zealand?

Question 6  How many years have you been designated as a responsible clinician?

(For questions 7–16 delete Yes or No as appropriate.)

Question 7  Have you received any training regarding the Mental Health Act 1992?  Yes  No

Question 8  Have you received any training regarding the 1999 amendment of the Mental Health Act 1992?  Yes  No

Question 9  Are you familiar with the requirements to consult with family/whānau under Section 7A of the Mental Health Act?  Yes  No

Question 10 Have you read the Section 130(a) Guidelines from the Ministry of Health with regards to family/whānau consultation?  Yes  No

If yes, please note any views you have of this document.

Question 11 Have you read the RANZCP Involving Families Guidance notes?  Yes  No

If yes, please note any views you have of this document.

Question 12 Have you attended the workshop run jointly by the Ministry of Health and the Health Research Council on family/whānau involvement for the mental health workforce?  Yes  No

If yes, please note any views you have on this workshop.
Question 13  If you were a responsible clinician prior to April 2000 (the enactment of the 1999 Amendment), do you believe your practice changed following the amendment?  
Yes  No  
If yes, please describe how.

Question 14  Does your process of family/whānau consultation at section 10 (preliminary assessment) differ from other stages of the Mental Health Act (for example, section 14, 29, 30, 76) or when considering discharge from the Act?  
Yes  No  
If yes, please describe how.

Question 15  Do you believe the current requirements of the MHA allow for the adequate inclusion of family/whānau?  
Yes  No  
Please elaborate.

Question 16  Were you aware that family/whānau consultations are mandatory by law subject to specific exceptions?  
Yes  No

Any further comments/thoughts?
Appendix F: People and Organisations who Made Submissions

Barbara Laird, Family Advisor, Henry Rongomau Bennett Centre
Caring Communities Inc
Child, Adolescent and Families Rep Group, Canterbury District Health Board
David Bates, District Inspector
David J Turner
Health and Disability Commission
Heather Ottley, SF
Maryse Stanton, Family Advisor, Otago District Health Board
Maureen Carruth
Mental Health Commission
New Zealand College of Mental Health Nurses Inc
Pauline Hinds, Consumer Advisor
Regina Pernice, Lecturer in Rehabilitation Studies Mental Health, Massey University
Rex Maidment, District Inspector
Royal Australian and New Zealand College of Psychiatrists, New Zealand Branch
Sandy Barry, District Inspector
Sensible Sentencing Trust
SF Aoraki
SF Manawatu
SF Southland
SF Waikato
SF Wairarapa
SFNZ Inc, National Office
Sheryl Chiang and Pip Scott, Family Advisors, Canterbury District Health Board
South Island Family/Whānau Network Group
Susan Hamp
Tim Alcock
Trevor Burton

One submission-writer asked to remain anonymous.
One submission was from an unidentified family advisor.
One submission was from an unidentified SF member.
Appendix G: Guidelines to the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (section 1.4)

The following extract is from Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2000: 17–18).

1.4 ‘Principal caregiver’

The Act defines the ‘principal caregiver’ to mean ‘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’. The fact that the patient does not give the name of the principal caregiver, or does not authorise, or even forbids, the principal caregiver being contacted, does not affect the statutory duty to send the principal caregiver a copy of the certificate of preliminary (section 10(4)(a)(iv)), further (section 12(5)(d)), and final (section 14(4)(b)(iv)) assessment, and a copy of a certificate of clinical review that states that the patient is not fit to be released from compulsory status (section 76(7)(b)(iii)).

The Privacy Act 1993 (the Privacy Act) does not affect the clear statutory duty of notification in these circumstances (see EW, 24/1/96, DC Auckland, Judge McElrea), nor does the Health Information Privacy Code or the Code of Health and Disability Services Consumers’ Rights (the Code of Rights).

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/whānau
- friends of the patient
- health professionals in the service
- other parties concerned with the care of the patient, for example prison staff.

If the patient is competent to make a decision about who is the principal caregiver, his or her advice as to who the principal caregiver is should be accepted.

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

- whether the patient is competent to advise whom the principal caregiver is; and
- who the ‘principal caregiver’ is for the purposes of the Act

should be that of the Director of Area Mental Health Services (DAMHS), who will be advised by the responsible clinician or appropriate [Duly Authorised Officer (DAO)] involved. In cases of dispute, the DAMHS should consult with other knowledgeable parties, for example a key worker. In cases of dispute with patients who identify as Māori, the DAMHS should also consult with Māori health workers and cultural support staff.

It is important to note that in Re H M, 4/4/99, FC Auckland, Judge Inglis, it was held that more than one principal caregiver may be appointed.
Appendix H: Guidelines to the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (section 4)

The following extract is from Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2000: 22–28).

4 Section 7A: Requirement to consult with family/whānau

Section 7A of the [Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (the Act)] requires a medical practitioner or responsible clinician to 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.

When making a decision about whether it is in the best interests of the patient or proposed patient, a medical practitioner or responsible clinician must first consult with the patient or proposed patient.

A clinician is required to apply any relevant guidelines and standards of care and treatment issued by the Director-General of Health (issued under section 130 of the Act) when deciding:

- when and how to consult family/whānau or the patient or proposed patient
- whether or not consultation with family/whānau is reasonably practicable
- whether or not consultation with family/whānau is in the best interests of the patient or proposed patient.

4.1 General comments

It is unlikely that the requirement to consult will address all family/whānau concerns regarding the compulsory assessment and treatment of their family/whānau member. It is also possible that section 7A of the Act may unduly raise family/whānau members’ expectations about their role in clinical decision-making. It may also unduly raise the hopes of family/whānau that they will be involved in daily decisions concerning the care of their family/whānau member. Nevertheless, the requirement to consult should ensure more informed decisions are made.

It is the Ministry of Health’s expectation that the requirement to consult with family/whānau will:

- strengthen family/whānau involvement in the compulsory assessment and treatment process
- enhance the contribution the family/whānau can make to subsequent care
- go some way towards addressing family/whānau concerns about information sharing and education about treatment options.

A patient or proposed patient’s consent to consult family/whānau should be obtained wherever possible. The requirement to consult does not mean that a patient or proposed patient completely forfeits his or her right to confidential care and treatment. The rights of proposed patients and patients and the protection of those rights continue to be paramount and one of the major philosophical tenets of the Act.

4.2 Family and whānau
People’s definitions and understanding of family/whānau vary and are informed by different cultural backgrounds and practices. The perspective of the person who identifies membership of a family/whānau is a critical factor in that process. The following definition is only one definition of family/whānau and is by no means the only definition. However, to avoid confusion it is recommended that the following definition be used as a guide.

Family/whānau is a set of relationships that is defined as family/whānau by the patient or proposed patient. A family/whānau is not limited to relationships based on blood ties and may include:

- relatives of the patient or proposed patient (including a spouse or partner); or
- a mixture of relatives, friends, and others in a support network; or
- only non-relatives of the patient or proposed patient.¹

In some circumstances, a proposed patient or patient’s definition of family/whānau will be at variance with this definition. If the patient or proposed patient is competent to make this decision, his or her advice as to what family/whānau is should be accepted because the patient or proposed patient is the ‘expert’ about most situations. In cases of doubt or dispute, the responsibility for the decision about:

- whether the patient or proposed patient is sufficiently competent to advise staff who the family/whānau is; and
- who the family/whānau is for the purposes of the section 7A of the Act

should be the responsibility of the DAMHS. The DAMHS will make this decision based on the advice of the responsible clinician, medical practitioner, or key worker. If the patient or proposed patient identifies as Māori, the DAMHS should seek advice from Māori health workers and cultural support staff. In urgent circumstances, the clinician completing sections 10 and 11 of the Act would be responsible for this decision for the purposes of the Act.

In cases of dispute, the DAMHS should consult other knowledgeable parties, for example the patient or proposed patient’s usual general practitioner, key worker, Māori health worker, kaumātua, cultural support staff, Māori consumer advisory groups, Māori advisory committee, and other Māori providers of services to the patient or proposed patient, or a District Inspector.

### 4.3 Consultation

#### 4.3.1 How to consult

In practical terms, consultation means objectively talking with affected parties and listening to what they have to say. It does not simply mean sharing information.

Consultation does not require agreement, nor does it necessarily involve negotiations towards an agreement, although this might occur – particularly as the tendency in consultation has been at least to seek consensus.²

Meaningful consultation consists of the following steps.

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¹ Royal Australian and New Zealand College of Psychiatrists. Draft Guidelines for Involving Families of Mental Health Consumers in Care, Assessment, and Treatment Processes (in press).
² Wellington Airport v Air New Zealand [1993] 1 NZLR 671.
Consulting in the formative stages of a process by giving adequate notice of a proposed decision or action (that is not yet finally decided upon) to affected and/or interested parties.

Providing a reasonable amount of time for affected and/or interested parties to respond (this will depend on the urgency of the issue).

The party required to consult can have a working plan in mind and inform interested/affected parties of this plan, but must keep an open mind and be ready to change or start afresh should this be required. It is important to note that consultation does not mean that clinical safety should be compromised.

Providing affected and/or interested parties with a reasonable opportunity to formulate and state their views in a safe and open environment.

Giving proper consideration to the representations of the affected and/or interested parties before deciding what will be done.

Providing feedback to affected and/or interested parties on the outcomes of the consultation.

4.3.2 When to consult

Consultation with families/whānau is not a one-off event but an ongoing process. It is recommended that a medical practitioner or responsible clinician should consult when:

- significant treatment decisions are being made
- at each juncture of the compulsory assessment and treatment process, that is sections 9, 10, 14, 29, and 30 of the Act; reviews under section 76 of the Act; or when the practitioner or clinician is considering discharging the patient from the Act.

This may require the disclosure of a proposed patient or patient’s personal and health information to families/whānau.

The disclosure of information for the purposes of consultation under section 7A of the Act is not a breach of the Privacy Act or the Health Information Privacy Code.³

4.3.3 Consulting with a patient or proposed patient

A medical practitioner or responsible clinician must firstly consult with the patient or proposed patient to ascertain his or her views when making a decision to consult with family/whānau. The practitioner or clinician must also provide the patient or proposed patient with an opportunity to respond.

A patient or proposed patient can refuse to give permission for a medical practitioner or responsible clinician to consult with family/whānau. In this situation it is up to the practitioner or clinician to then decide whether consulting with family/whānau would be in the ‘best interests’ of the patient or proposed patient.

³ See section 7 and section 53 of the Privacy Act 1993.
If the circumstances are urgent, a medical practitioner or responsible clinician should still talk with the patient or proposed patient and seek his or her views, but given the urgency the clinician may decide that it is either not in the best interests of the patient or proposed patient or reasonably practicable to consult family/whānau at that particular time. However, this should not necessarily preclude the clinician from communication with the family/whānau after a particular decision has been made, that is at the earliest possible opportunity, and before further subsequent action is taken.

4.3.4 Consulting with family or whānau

Medical practitioners or responsible clinicians who consult with family/whānau must use discretion to decide how much information to give to family/whānau. A practitioner or clinician must consider how much information a family/whānau needs to make informed and useful responses to the practitioner’s or clinician’s proposed course of assessment or treatment. The practitioner or clinician may have a working plan in mind but must keep his or her mind open and be ready to change or start afresh if this is required.

Consultation with the family/whānau of patients or proposed patients who identify as Māori should involve relevant Māori health workers, kaumātua, cultural support staff, tangata whai ora advocacy services, Māori advisory committees, or other Māori providers of services to patients or proposed patients who identify as Māori.

4.3.5 Best interests

‘Best interests’ is a concept that is used elsewhere in the Act (sections 19 and clause 2 of the First Schedule). The importance of the ‘best interests’ concept is that the interests of the individual come ahead of anybody else’s interests. In some cases, there may be a clash of interests between an individual and his or her family/whānau. The ‘best interests’ assessment means that those charged with applying it (the medical practitioner or responsible clinician) must resolve any such clash in favour of the individual about or for whom they are making a decision. In some situations in which individuals’ wishes are considered to be contrary to their own ‘best interests’, this may result in the practitioner or clinician charged with applying the best interests concept acting contrary to the wishes of the individual.

In relation to section 7A(3)(a) of the Act, a medical practitioner or responsible clinician must have reasonable grounds for deciding that consultation with the family/whānau of a patient or proposed patient is not in his or her best interests. The need to make such a decision is only likely to occur when a situation arises in which the patient or proposed patient does not wish the practitioner or clinician to consult with the family/whānau yet the family/whānau wishes to be involved in the proposed patient or patient’s care and treatment.

To help determine the best interests of a patient or proposed patient, a medical practitioner or responsible clinician needs to consider all relevant clinical or personal information. Relevant information may include:

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4  Tangata whai ora means the one who is seeking wellness.
the reasons the patient or proposed patient wants his or her family/whānau excluded from his or her care
the wellness or competence of the patient or proposed patient to make such a decision
the clinical and family/whānau history of the patient or proposed patient
any previous contact the patient or proposed patient has had with other mental health service providers
the likelihood of the family having information not available from other sources
any advance directives the patient or proposed patient may have made.

If a patient or proposed patient identifies as Māori, the medical practitioner or responsible clinician needs to consult with Māori health workers, Māori providers, and cultural support staff involved in the patient or proposed patient’s care.

4.3.6 ‘Reasonable grounds’ and ‘reasonably practicable’

When considering whether consultation is ‘reasonably practicable’ the medical practitioner or responsible clinician needs to consider whether it is objectively feasible. Relevant factors to consider may be:

- urgency (ie, the safety of the patient or proposed patient or others). For example, if the patient or proposed patient is acutely unwell and the clinician needs to act quickly.
- the time taken to contact family/whānau members as well as the time required for family/whānau members to formulate their views
- expenses (for example, if a patient is in Auckland and their family/whānau lives in Invercargill it may be more feasible to consult using the telephone or videoconferencing rather than meeting face to face)
- any other disadvantage.

A medical practitioner or responsible clinician needs to balance any disadvantages with the potential benefits to the patient or proposed patient.

If the medical practitioner or responsible clinician decides that consulting with family/whānau is not in the best interests of the patient or proposed patient, the following points should be taken into account:

- the clinician can still seek information from the family/whānau
- the family/whānau can continue to provide information to the clinician
- the family/whānau may be given information that was collected for the purposes of disclosure to the family/whānau where the family/whānau is providing ongoing care (eg, information about medication prior to discharge)
- the family/whānau may be given information if the practitioner or clinician considers it will prevent a serious threat to the life or health of the patient or family/whānau members.

4.4 Māori

Māori have a distinct need for family/whānau involvement, as Māori generally see themselves more as members of their family/whānau than as individuals. The emphasis

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6 The term ‘reasonable’ brings a measure of objective consideration to a decision, that is whether with knowledge of the same facts another responsible clinician would make the same decision.
that the Act places on the individual patient or proposed patient conflicts with the
‘whānaungatanga’ concept of interdependence and the interconnectedness between all
members of the whānau, including the tangata whai ora. Any decisions concerning Māori
individual interests versus family/whānau interests should not be made solely by a medical
practitioner or responsible clinician. Rather, there must be involvement by Māori health
workers, kaumātua, cultural support staff, tangata whai ora advocacy services, Māori
advisory committees, and other Māori providers of services to tangata whai ora.

In order to implement section 7A of the Act appropriately and to ensure that mental health
staff work effectively with family/whānau, staff may need:
   specific training resources
   appropriate cultural expertise
   to be supported by organisational development.

Māori have diverse realities and every family/whānau needs recognition and to retain
cultural safety as it participates in care, assessment, and treatment processes.

To lessen the risk of inappropriate service delivery and to ensure that family/whānau
remain culturally safe, mental health services may need to put a number of fundamental
mechanisms in place. These should include:
   ensuring the involvement of kaumātua
   seeking guidance from other appropriate Māori support staff such as Māori health
   workers, Māori advisory group members, or tangata whai ora advocates
   seeking advice relating to tikanga Māori
   providing cultural safety training to staff
   ensuring the flexibility and responsiveness of staff.

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

The above comments apply equally to a proposed patient or patient who identifies as a
Pacific person.
References


