

Mental Health and Human Rights

Submission form

Please take the time to make a submission. The final pages of this consultation document explain how to make a submission and how to make sure it reaches the Ministry in time. There are also questions that might help you to write your submission.

Your feedback is important: it will contribute to a shared understanding of the relationship between the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Convention on the Rights of Persons with Disabilities (CRPD) and the New Zealand Bill of Rights Act 1990 (NZBORA). Your feedback will also shape recommendations to the Ministerial Committee on Disability Issues on the alignment of the Mental Health Act with CRPD and NZBORA.

All submissions are due with the Ministry by **5 pm on Friday, 24 February**.

The Ministry of Health must have your submission by this date and time. Any submissions received after this time will not be included in the analysis of submissions. In making your submission, please include or cite relevant supporting evidence if you are able to do so.

There are two ways you can make a submission:

- fill out this submission form and email it to:
MentalHealthAdmin@moh.govt.nz

or

- mail your comments to:
Mental Health Act and Human Rights Feedback
Office of the Director of Mental Health
Ministry of Health
PO Box 5013
WELLINGTON 6145

The following questions are intended to help you to focus your submission. It will help us analyse the feedback we receive on the plan if you can use this format. You are welcome to answer some or all of the questions, and you can tell us about other ideas or concerns you may have as well.

You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by: NZ College of Clinical Psychologists
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Email: Office@nzccp.co.nz
Organisation (if applicable): NZ College of Clinical Psychologists
Position (if applicable): _____

Are you submitting this as (*tick one box only in this section*):

- an individual or individuals (not on behalf of an organisation)
 on behalf of a group or organisation(s)?

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission and your name(s) will not be listed in the published summary of submissions, if you check the following box:

- I do not give permission for my personal details to be released.

Please indicate which sector(s) your submission reflects
(*you may tick more than one box in this section*):

- | | |
|--|--|
| <input type="checkbox"/> Māori | <input checked="" type="checkbox"/> Professional association |
| <input type="checkbox"/> Pacific | <input type="checkbox"/> Justice sector |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Education sector |
| <input type="checkbox"/> Consumers/families/whānau | <input type="checkbox"/> Social sector |
| <input type="checkbox"/> Service provider | <input type="checkbox"/> Academic/research |
| <input type="checkbox"/> Non-government organisation | <input type="checkbox"/> Local government |
| <input type="checkbox"/> Public health organisation | <input type="checkbox"/> Industry |
| <input type="checkbox"/> Primary health organisation | |
| <input type="checkbox"/> District health board | <input type="checkbox"/> Other (<i>please specify</i>): |

Questions

These questions relate to the Mental Health Act and its administration.

Part One: Overview of the Mental Health Act, CRPD and NZBORA

1. How well do you think the Mental Health Act does in promoting and protecting human rights?

In the experience of our members, the MHA and its associated processes are not designed for this purpose and therefore the preservation of rights is seen as peripheral, rather than central to its implementation. Whereas most staff will receive training and be able to describe the powers to *restrict* a person's rights, particularly utilising the MHA, very few will receive training on *what those rights are* (although perhaps the Code of Rights will be covered). Similarly, most consumers would be unaware of their rights under NZBORA.

Typically, the MHA is utilised to restrict an individual's rights to self-determination, in the context of mental disorder, based upon a perceived clinical risk. However, there is considerable psychological evidence that perceptions of risk are influenced by a number of factors, which can lead to an over- (or under-) estimation of actual levels of risk. In this way, there is good evidence that individuals from minority ethnic groups (Maori and Pasifika in the NZ context), those with cognitive and physical disabilities and those with higher body-mass index often have their rights disproportionately restricted.

Clinical psychologists are often involved in working with consumers who experience considerable trauma as a result of restrictive practices and we believe that human-rights based approaches hold considerable promise in improving outcomes for Mental Health consumers.

2. What changes do you think are needed in order to make the Mental Health Act and its administration more aligned with our obligations under NZBORA and the CRPD?

We note the conflict between MHA and CRPD, which we feel would be difficult to resolve without a significant change to the MHA. As the consultation document notes, the concept of ‘capacity’ is not well-defined in NZ law (MHA nor PPPRA- although we note the definition in accompanying guidance) and therefore the MHA can be seen to assume a lack of capacity, based on the presence of ‘mental disorder’, which can itself be considered discriminatory.

One radical alternative might be to form a ‘3 stage’ test for the MHA, similar to the ‘2 stage’ test in the UK Mental Capacity Act. That is 1) that the person is experiencing a ‘mental disorder’ (in current terminology), 2) that the person is currently unable to understand, retain, weigh and communicate information relevant *to the treatment of their condition* (it must be specific to this). A third stage ‘test,’ or condition, might be (under common law) that the intervention must be proportional to the level of perceived risk of not receiving treatment (i.e. compulsory treatment being only utilised in the context of significant and pressing risk).

Regardless of the means of detention, we would certainly argue that NZBORA and the CRPD must be placed, explicitly, at the centre of MHA training and administrative processes- with clear information available to clients, whanau and staff on the rights of individuals utilising the service. As noted above, there is good evidence to show that there is an over-emphasis upon perceived clinical risk in decision making, with little consideration given to the effects of restricting an individual’s rights.

There is also good, emerging international evidence of the effectiveness of Human-Rights based approaches in Mental Health services (see Porsdam Mann, Bradley & Sahakian, 2016), reducing the use of restrictive practice and minimising institutional discrimination, and we would urge the Ministry to look closely at these emerging models of care (see also attached document).

Part Two: Mental Health Act – the Issues

Individual autonomy/consent

3. Do you think the views and preferences of tangata whairoa / service users are taken into account sufficiently in decisions about their treatment? What is your experience?

The experiences of our membership appear to vary considerably- in many (perhaps the majority of) instances, we would agree that the views of tangata whairoa/service users are very much considered and taken into account. However, our membership noted many occasions where views and preferences were either not sought or, when stated, ignored completely.

4. What is your experience of consultation with the families and whānau of both adults and young people subject to the Mental Health Act, including in relation to treatment options? Is it culturally appropriate? How could it be improved?

Similarly to the points made above, the experiences of clinical psychologists can vary considerably- with some examples of good practice and others of extremely poor practice being noted.

One of the most noted conflicts was between the wish to involve family/whanau, and the client's wish *not to* have them involved- which remains an extremely difficult balance to strike. Many mental health users are estranged from their family/whanau and, without considerable discussion with tangata whaiora/service users and considerable effort on the part of staff, re-establishing family connections can frequently be difficult- particularly during short-term admission/treatment. In our view, more assertive attempts to engage family/whanau (and the individual) in shared care planning would be a significant improvement- however, we note that this is often limited by time and the wishes of the tangata whaiora/service users.

Advocacy and support

5. How might tangata whaiora/service user decisions be better supported?
 - a. What supports are needed by seriously ill mental health patients to make decisions?
 - b. What about those persons with mental illness who do not have support networks?
 - c. What is the role of peer support, independent advocates and advance directives in supporting decision-making?

As noted above, if Mental Health legislation was to consider that clients must be lacking in capacity to make decisions regarding their treatment, in order to come under the Act, then it would be important to place an emphasis upon service providers to *make efforts to help them* with these decisions. The UK Mental Capacity states that people must be given all appropriate help and support to enable them to make their own decisions and/or to maximise their participation in any decision-making process.

Regardless of whether they have support networks, we believe that all individuals should be offered (of course, they may decline) independent advice to support their decision making. We note the role of the District Inspectors in the current Mental Health system, which we consider a positive one, but also the criticisms that are mentioned in the consultation document. Peer support and peer advocacy can be extremely helpful but they can also be problematic- particularly if the peer advocate has their own negative view of services and cannot offer *independent* advice.

Checks and balances in the system

6. Does the current system of protections under the Mental Health Act adequately meet the needs of people under the Act? What are the gaps and where do you think improvements could be made, including for:
 - a. Māori tangata whaiora /service users?
 - b. Pasifika tangata whaiora / service users?
 - c. people from other cultural/ethnic backgrounds?
 - d. young people?
 - e. people with learning disabilities and cognitive impairments (including older people with dementia)?

In the context of assessing and attempting to maximise tangata whaiora/service users' ability to consent to (or refuse) mental health treatment, most of the above groups could be considered extremely vulnerable. In many populations (particularly in Pasifika groups, young people and those with autism or with intellectual and cognitive impairments) there is considerable psychological research related to acquiesce to authority- the tendency, when not fully understanding, to agree to a course of action recommended by a doctor. This can be in the context of compulsory treatment (difficulties advocating for themselves) or indeed 'voluntary' treatment (see the 'Bournewood' case in the United Kingdom).

As noted above, there is considerable evidence that many of these groups are also disproportionately subjected to restrictive practices such as seclusion, restraint and over-medication. Some of this appears to be due to cognitive bias amongst risk assessors, but also due to a lack of specialist clinical knowledge- a lack of familiarity with any population tends to increase perceptions of risk and increase restrictive practice.

We would argue that there is a clear need for better identification of these issues, training of appropriate support staff and referral to appropriate independent advocacy, as a minimum.

Respect for cultural identity and personal beliefs

7. What is your experience of cultural competency in the services provided under the Mental Health Act? When should cultural assessment be used?
8. What do you think constitutes 'proper recognition' of whānau, hapū and iwi in terms of use of the Mental Health Act? (This is set out in the Mental Health Act guidelines: it is not defined, but it is described).
9. What changes would you like to see?

We believe that the importance of sensitivity to individual difference cannot be overstated- although our members' experience suggests that sensitivity and responsiveness can vary significantly from services to service. What represents 'cultural assessment' can similarly have different meanings between services- some advocating an 'integrated' approach (where knowledge is held within the service, as part of a holistic approach) and other a 'specialist' approach (where the knowledge is held outside the service, utilising external consultants to conduct assessments). There are clear advantages and disadvantages to both approaches, however a mixed approach (strong internal cultural competency, alongside the availability of external consultants) appears to offer the best range of supports.

Compulsory treatment orders

10. Do you think the threshold for initiating, extending and moving people onto a compulsory treatment order is too low? Please comment.
11. What is the impact on individuals of being placed under a compulsory treatment order (inpatient or community) and on the therapeutic relationship between the individual and their clinician/clinical team?
12. Can the process of moving from voluntary treatment to compulsory assessment and treatment be improved? If so, how?
13. What role does access / lack of access to timely and appropriate services (inpatient and in the community), including early intervention and crisis resolution, play in people being placed under compulsory assessment and treatment?

There is clear research evidence to suggest that clinicians' assessment of clinical risk is extremely poor (recent meta-analyses have suggested it is little better than the toss of a coin). It is clear that some individuals are placed on compulsory treatment orders when they do not require it and it is also clear that individuals are not placed on such orders when they are at severely unwell and at significant risk. Alongside the question of whether the threshold is too low (or high) we must consider how we identify who meets the threshold, which requires considerably more research.

In a significant proportion of cases, compulsory treatment will have an impact upon the therapeutic relationship between an individual and/or a service, although in many cases this can be recovered/surmounted. For this reason, there is some reluctance amongst Clinical Psychologists to be part of this process, which they consider damaging to therapeutic process.

As we have already noted, there is considerable qualitative evidence from tangata whaiora/service users, families/whanau and clinicians that there is currently insufficient access to psychological approaches within the mental health system. There is an enormous evidence base to suggest that 'talking' therapies are perhaps the most effective intervention in promoting recovery and minimising crises and that, in services for the most complex individuals, clinical psychologists are best qualified to offer the so-called 'level 3' skills- i.e. providing bespoke, tailor-made therapeutic recovery 'packages'.

Seclusion and restraint

14. What is your experience of seclusion and restraint? What do you think are the key changes needed to further reduce (and eventually eliminate) seclusion?

Attached is a more comprehensive position paper on this subject, recently prepared by the NZCCP for the Human Rights Commission.

Certainly, a large proportion of our members, their clients and clients' families, have noted that they have significant difficulties accessing support from clinical psychologists. Firstly, clients and families describe significant difficulties accessing 'talking therapies' that might prevent and/or ameliorate mental health crises. When they do, they typically access 'low level' therapy support (e.g. counselling), rather than from qualified clinical psychologists, trained in evidence-based approaches.

In our attached report, we argue that compulsory treatment cannot truly be considered a 'last resort' if psychological supports are not offered or made available.

Indefinite form of compulsory treatment order

15. What is your experience of and view on indefinite treatment orders?

As per the above discussion, the lack of ongoing review of indefinite orders offers considerable potential for restrictive treatments to continue, even when they are no longer necessary (c.f. the UK 'Bournewood' case).

Final comments

Is there anything else you want to tell us? If so, feel free to make any further comments here.

A significant issue with current mental health services, noted by our members, is the frequent conflation of mental health and perceived risk. As the Mental Health Act requires the presence of *both* a mental disorder *and* significant risk, it is often unclear whether compulsory treatment (particularly inpatient care) is aimed at treating an underlying mental disorder (which may not be possible during a brief, inpatient stay) or managing the risk (which may or may not be influenced by treatment).

Our members note that this conflict often leads to individuals who remain both unwell and risky being discharged from services when their condition is perceived as 'not amenable' to psychiatric treatment, as well as individuals who have low levels of risk remaining in hospital for long periods, as various approaches are taken to the treatment of their mental health condition. Furthermore, Clinical Psychologists noted that mental health environments often have to strike an uneasy balance between being 'secure' vs 'therapeutic', as a result of these conflicting roles.

The NZCCP welcomes this consultation, which we feel goes to the heart of some of the existing conflicts between preserving the rights of tangata whaiora/service users, successfully treating their mental health conditions and keeping them and others safe.

Please also find attached a recent position paper from the NZCCP on Clinical Psychology and Human Rights, in relation to the Human Rights Commission's review of Seclusion and Restraint in New Zealand, which we believe is relevant.