

28 February 2017

Mental Health Act and Human Rights Feedback
Office of the Director of Mental Health
Ministry of Health
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Mental Health and Human Rights

The New Zealand Law Society welcomes the opportunity to provide feedback on how the Mental Health (Compulsory Assessment and Treatment) Act 1992 relates to the New Zealand Bill of Rights Act 1990 and the Convention on the Rights of Persons with Disabilities. The Law Society's comments in response to the *Mental Health Act and Human Rights: discussion document* (discussion document) are set out below.

Q1: How well do you think the Mental Health (Compulsory Assessment and Treatment) Act 1992 does in promoting and protecting human rights?

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), although largely compliant with the New Zealand Bill of Rights Act 1990 (NZBORA), has areas of weakness in promoting and protecting human rights. The processes and procedures in the MHA need improvement in order to ensure that none of the compulsory powers are used inappropriately, and that patients are able to participate as fully as possible in processes that significantly affect them.

Q2: 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 Convention on the Rights of Persons with Disabilities (CRPD)?

Alignment with Obligations under NZBORA and CRPD

Regarding assessment and treatment:

A recognition of advance directives, to align the treatment of mental health patients with non-mental health patients, is needed.

Supported Rather than Substituted Decision Making:

Article 12 of the CRPD requires States Parties to ensure that a person with a mental disability has safeguards over the exercise of legal capacity and that "... *the rights, will and preferences of the person are free of conflict of interest and undue influence ...*". The MHA imposes decision-making rather than supporting those with mental disabilities (whether with reduced capacity or intermittent capacity) to make their own decisions. Patients' rights under Part 6 of the MHA include the right to independent psychiatric advice (s69) and legal advice (s70). The assignment of state-funded and

independent legal counsel and psychiatrists prior to the preliminary assessment (s9 MHA) is recommended, in order to give practical effect to these rights.

The MHA does contain review processes and the District Inspectors (s94) are lawyers entrusted with ensuring that patients' rights are protected. However, to enable supported decision making, the District Inspectors need to be allocated to specific individuals (if they don't have their own lawyer) and be responsible for those persons prior to the section 9 preliminary assessment.

Increased Home Support:

Article 19 CRPD requires that States Parties recognise the equal right of all persons with disabilities to live in the community and should have "... access to a range of in-home residential and other community support services including personal assistance necessary to support living and inclusion in the community ...". The MHA should be amended to recognise this right.

Q5(c): What is the role of peer support, independent advocates and advance directives in supporting decision making?

Independent Advocates:

As noted above, the MHA ensures all persons have the right to advice from independent advocates in the form of independent psychiatrists (s69) and legal counsel (s70). The Ministry of Health's 2012 *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*¹ recognise a person's right to legal advice: "...under section 23(1)(b) of the NZBORA 'everyone ... who is detained under any enactment ... shall have the right to consult and instruct a lawyer without delay and to be informed of that right'. This right to legal advice extends to proposed patients."

However, given that a proposed patient's mental capacity to exercise their right to legal counsel or an independent psychiatrist may be limited or intermittent, special consideration should be given to how they may be able to exercise these rights.

Article 12(3) CPRD requires that "*States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.*" It is recommended that an independent lawyer and psychiatrist be appointed at the earliest stages (prior to assessment under s9 MHA) and before any action is taken. This is a necessary step in order to maintain the rights of the person with the mental disability.

Advance Directives:

Advance directives will not override the ability of the clinician to authorise compulsory treatment of a person under the MHA, although under the Ministry of Health's Guidelines, where possible the clinician should take steps to give effect to prior, competently expressed wishes. Article 12(4) CPRD provides that States Parties must "... respect the rights, will and preferences of the person ..." and, provided an advance directive was written freely, in competence, with an understanding of the consequences and in relation to the facts at hand, then not to follow it may be in breach of the CPRD.

¹ <https://www.health.govt.nz/system/files/documents/publications/guide-to-mental-health-act.pdf> at section 11.7.

Q6: Does the current system of protections under the Mental Health Act adequately meet the needs of people under the Act? Where 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)?**

Section 5 MHA requires powers to be exercised with “proper respect for cultural identity and personal beliefs”. The question whether these needs are being met, and what improvements can be made, is best answered by the groups identified in (a) – (e) above. The discussion paper refers to existing feedback from Māori and Pasifika persons and the Elder & Tapsell report. There should be further engagement with tangata whaiora and their supporters, and serious consideration given to their recommendations regarding the improvements needed.

Specific focus groups should be created to talk with young people about how the MHA can meet their needs. Conversations with young people from all demographics who have either themselves been exposed to mental health issues or had family or friends exposed to it would be useful. Also, hearing from those who have experienced the effects of treatment and detention under the MHA is vital in learning how their needs are currently being met and what improvements are needed.

The opinions of people with learning disabilities and cognitive impairments, including dementia, should also be canvassed. Depending on the type and severity of their learning disability or cognitive impairment some persons may find it useful to have the questions posed in a different manner, or presented in different ways (verbal rather than written etc.). Those with severe disabilities who are without capacity to participate directly in such activities may still benefit from the first-hand experiences of their families and caregivers being sought on their behalf.

Q14: What is your experience of seclusion and restraint? What do you think are the key changes needed to further reduce (and eventually eliminate) seclusion?

Seclusion:

Seclusion (s71 MHA) raises acute issues of compliance with Article 14 (Liberty and Security of Person) of the CRPD. The concluding observations of the Committee on the Rights of Persons with Disabilities with regard to New Zealand’s compliance recommends “*immediate steps be taken to eliminate the use of seclusion and restraints in medical facilities.*” The UN Working Group on Arbitrary Detention has also urged New Zealand authorities to eliminate this practice.²

Brief and immediate separation of a person from other persons in a facility to prevent physical harm may be needed, but this should be for a matter of hours only and in the same manner as would be applied to any person exhibiting immediate and dangerous behaviour.

Article 14 of the CRPD does have a qualification allowing persons with disabilities to be deprived of their liberty through any process, provided “... *it is on an equal basis with others ...*”.

² Discussion document, p31.

It is the use of seclusion as a treatment measure (with an open-ended timeframe) which is the concern. There could be value in cross-checking the current regulation of seclusion with the treatment of this issue under other regimes such as the Corrections Act 2004.

Restraint:

The discussion document notes that the manner and degree of restraint permitted is not addressed in the Act (this is instead set out in standards).³ As with seclusion, the justification would have to be immediate with a real threat of bodily harm, and the length of time it was used would have to be minimal – no more than for any other person who posed such a threat. Again, cross-checking against other legislative regimes, such as the Corrections Act, could be useful. In any case the MHA should make clear the exceptionality of the use of restraints.

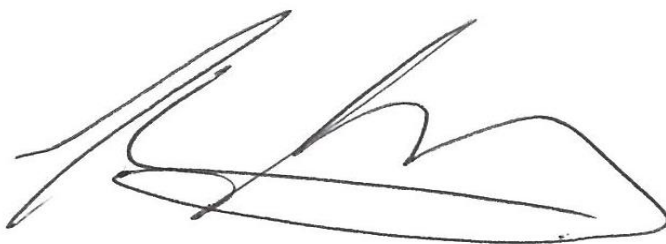
Q15: What is your experience of and view on indefinite treatment orders?

Section 34(4) MHA is in direct conflict with Articles 1 (full and equal enjoyment of all human rights and fundamental freedoms) and 14 (the existence of a disability shall in no case justify a deprivation of liberty) CRPD, and sections 18 (freedom of movement), 19 (freedom from discrimination) and 22 (liberty of the person) NZBORA. Indefinite compulsory treatment orders should be abolished. There should be a periodic review of detention, even if it is on a more infrequent basis than the reviews that precede it (e.g., every two years rather than every six months). This is implicit in the approach adopted by the UN Human Rights Committee, in *Rameka v New Zealand* (2003) 7 HRNZ 663, paras 7.2 – 7.4, to the operation of New Zealand’s preventive detention regime.⁴

Conclusion

If further discussion would assist, or if you have any questions about the Law Society’s comments, please do not hesitate to contact Dr Andrew Butler, convenor of the Law Society’s Human Rights and Privacy Committee. Dr Butler can be contacted in the first instance through the Law Society’s Law Reform Manager, Vicky Stanbridge (vicky.stanbridge@lawsociety.org.nz / 04 463 2912 ddi).

Yours faithfully



Kathryn Beck
President

³ Discussion document, p31.

⁴ *The New Zealand Bill of Rights Act: A Commentary*, Butler & Butler, 2nd ed., Lexis Nexis 2015, at 19.8.10.