Mental Health and Wellbeing Commission submission on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill

Submitted to the Health Select Committee on 19 May 2021

Tēnā koe,

He Ara Oranga calls for the repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) so that it reflects a human rights-based approach that promotes supported decision making, aligns with the recovery and wellbeing model, and minimises compulsory and coercive treatment.

We recognise the Mental Health (Compulsory Assessment and Treatment) Amendment Bill (the Amendment Bill) is an interim step to address some concerns about the Act while a permanent solution is underway. We consider some of the proposed changes in the Amendment Bill represent a step toward human rights-based mental health legislation.

We have heard from communities that the repeal and replacement of the Act is crucially important. It must centre Te Tiriti o Waitangi, human rights, and recovery-based approaches. People with lived experience of compulsory treatment have expressed the need for an inclusive process to design the repeal and replacement of the Act, where their input is actively sought and enabled. Alongside communities, we look forward to seeing a clear timeline for the review process.

We also support work being undertaken by the Health and Disability Commissioner to ensure the Health and Disability Service Consumers' Code of Rights is promoted and understood, regardless of a persons' legal status under the Act.

Our submission is structured to address the three key aims of the Bill:

- **Part one** eliminating indefinite treatment orders
- **Part two** minimising the risk of harm to the person or the public when transporting people who are 'special patients'
- **Part three** removing the sunset date for technical amendments and audio-visual link amendments made during the COVID-19 Response

Thank you for considering our submission. We also request the opportunity to make an oral submission.

Ngā mihi,
Hayden Wano

Chair, Mental Health and Wellbeing Commission

Part one - eliminating indefinite treatment orders

1. Compulsory treatment orders override the right[1] for a person (patient) to consent to treatment, even where the person maintains the capacity to make informed choices and give consent. This violates Article 12, Equal Recognition Before the Law, of the Convention on the Rights of Persons with Disabilities.
2. Treatment orders become indefinite after two Court granted extensions (six and 12 months from the initial order). This means that people who are placed under an indefinite treatment order have no certainty about if or when a clinician will reassess the grounds for their compulsory treatment. Indefinite treatment orders currently affect 2500 people.[2]
3. Māori are subject to unacceptably high rates of both compulsion and indefinite compulsion. In 2019, Māori were almost three times more likely to be subject to an indefinite community treatment order or an indefinite inpatient treatment order, than non-Māori.[3]
4. The Amendment Bill proposes to remove indefinite treatment orders. Instead, there is a new section proposed that says where a treatment order has been extended twice, there must be a clinical review before the second extension expires, and the clinician can apply to the Court for an extension of the order for a period of 12 months.
5. People under compulsory treatment orders would still have a clinical review every six months, and the right to apply to the Tribunal for a review of their condition after the clinical review.

The Commission supports the removal of indefinite treatment orders but consider a six-month extension to be more appropriate than twelve

6. Indefinite treatment orders are a serious breach of human rights and are incompatible with a recovery approach to mental health. Because of this, we support their removal.
7. However, we are concerned about the impact of the suggested 12-month extension period. This is a significant length of time in people's lives and their recovery journeys. While six-month clinical reviews will continue, the onus for applying to remove the order following clinical review is on the person. Not only is this a huge burden on the person, but the number of people who apply for a review of their compulsory status is low – less than three percent in 2016 / 17.[4]

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[1] Right 7, Code of Health and Disability Services Consumers' Rights.
[2] *Initial Amendments to the Mental Health (Compulsory Assessment and Treatment) Act 1992* Cabinet Paper
[3] Office of the Director of Mental Health and Addiction Services Annual Report 2018 and 2019
[4] *Initial Amendments to the Mental Health (Compulsory Assessment and Treatment) Act 1992* Cabinet Paper

Because of this, we consider a maximum six-month extension to be more appropriate.

8. Of those people who apply for a review, less than 20 percent are Māori. This suggests barriers to applying for a review as there are a high proportion of Māori people subject to compulsory treatment orders, yet a low percentage seek a review. These barriers need to be understood and reduced.

The Commission will continue to monitor the Government's progress toward a full repeal and replacement of the Act

9. We will continue to monitor the Government's progress toward a full repeal and replacement of the Act (He Ara Oranga Recommendation 34). This includes the necessary process of genuine partnership and collaboration with people who have the most at stake – those who have experienced detainment and forced treatment, and populations who currently have inequitable experiences of compulsion. The Human Rights implications, and implications for Tino Rangatiratanga for Māori, will need to be fully addressed through the repeal and replacement process.

Part two – minimising the risk of harm to the person or the public when transporting people who are 'special patients'

10. The Amendment Act proposes allowing 'custodians' of people who are special patients to use reasonable force, including restraint, to transport the person only if absolutely necessary and only if it is the 'safest and least restrictive option'. This will require a transport management plan that must be approved in writing by the Director of Mental Health.

11. According to the Departmental Disclosure Statement, this change has been made following concerns for the safety of people who are special patients and the public, raised by the Directors of Area Regional Forensic Mental Health Services.

If the proposed Amendment about restraint when transporting special patients comes into effect, we would like to see guidelines on the use of the least restrictive options, and regular reporting on the number of patients restrained

12. We understand the intent of this Amendment is to clarify the process of transporting special patients who are deemed to be high risk, as the Act is not clear on this matter.

13. We have heard from people in the lived experience community that the reasons for this Amendment are unclear. We would like the Ministry of Health to provide information on the current practice for transporting people who are special patients, and the associated problems that have led to this proposed amendment.

14. If the proposed Amendment comes into effect, we would like to see guidelines outlining the process for determining the least restrictive option, and how patients subject to restraint will be supported following restraint. We also expect regular reporting on the number of special patients who are restrained during transport.

Part three – Removing the sunset date for technical and audio-visual link amendments made during the COVID-19 Response

Amendment allowing families, whānau, and caregivers to be present using audio-visual links

15. Prior to the COVID-19 pandemic, family, whānau, or caregivers of people who are patients or proposed patients had to be present in person to participate in compulsory treatment order assessments and reviews.

16. During the COVID-19 restrictions under Alert Levels 3 and 4, the presence of family, whānau, or caregivers by audio visual or audio only link was made permissible to reduce transmission risks. The Amendment Bill makes this change permanent.

The Commission supports the amendment that allows families, whānau, and caregivers to be present using audio-visual links to be made permanent

17. We support making this Amendment permanent as it increases accessibility and gives patients more access to whānau support and involvement.

Amendments associated with the COVID-19 Further Measures Act

18. The COVID-19 Response (Further Management Measures) Legislation Act 2020 (COVID-19 Further Measures Act) included amendments to explicitly permit the use of audio-visual technology for assessments, examinations, and reviews of patients and proposed patients by providers, judges, and the Tribunal when physical presence of the patient is not practical.

19. Section 34C of the Amendment Bill states the use of audio-visual technology for the examination and hearing of application for extension of community treatment order is contingent on patient consent. However, section 6 of the Act (which the Amendment Bill proposes making permanent) does not explicitly note the requirement of patient consent.

20. Technical amendments to the Act made by the COVID-19 Further Measures Act were made to clarified wording, and to help timely assessment of people and better use of the health workforce.

21. This included changing:

    a) references to ‘medical practitioner’ and ‘health practitioner’ to ‘mental health practitioner’ (defined as ‘medical practitioner, nurse practitioner, or a registered nurse practising in mental health’)

    b) references to ‘medical examination’ to ‘examination’ in certain sections.

22. These changes currently expire on 31 October 2021. The Amendment Bill proposes making these changes permanent.

The Commission supports technical amendments to the Act, and permanently allowing the use of audio-visual technology for patient assessment, examinations, and reviews, only if patient consent is required

23. We only support making the use of audio-visual technology permanent on the basis that it will include patient consent. We would like to see the inclusion of patient consent in Section 6A of the Act.

Summary of our position

24. The Mental Health and Wellbeing Commission will continue to monitor the Government’s progress toward a full repeal and replacement of the Act.

25. The Commission:

    - supports the removal of indefinite treatment orders but consider a six-month extension to be more appropriate than twelve.
    - supports the amendment that allows families, whānau, and caregivers to be present using audio-visual links to be made permanent.
    - supports technical amendments to the Act, and permanently allowing the use of audio-visual technology for patient assessment, examinations, and reviews, only if patient consent is required.

26. If the proposed Amendment about restraint when transporting special patients comes into effect, the Commission would like to see guidelines on the use of the least restrictive options, and regular reporting on the number of patients restrained.