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To Heather Raeburn
Ministry of Health
Mental Health and Addiction Directorate
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18 January 2020

RE: Submission on the proposed draft revision of the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act (1992)* from Te Ao Māramatanga- New Zealand College of Mental Health Nurses

Kia ora Heather

Thank you for the opportunity to provide feedback on these very important guidelines. Please find below our submission.

Ngā mihi nui
Suzette Poole (President) and Chrissy Kake (Kaiwhakahaere)

SUBMISSION

Te Ao Māramatanga is the professional body and voice for Registered Nurses with specialist mental health knowledge and skills in New Zealand. In 2018, the College launched two new national branches- one for addiction nurses and one for disability nurses. Our submission therefore reflects mental health nursing, addiction nursing and disability nursing.

Thank you for the opportunity to comment on this proposed revised draft of the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act (1992)*. This submission has been prepared following consultation with as many members as possible given the relatively tight time frame and intervening holiday period. The Te Ao Māramatanga- NZCMH Nurses acknowledges the work that has gone into this new guideline and the significant shift towards respect for consumer autonomy and the Ministry's response to the issues raised by the recent Review of Mental Health and Addiction, *He Ara Oranga*. The College made a submission to the review which covered many of the issues identified in the proposed revision. The College also made a submission to the 2017 mental health and human rights assessment of the 1992 legislation. The College acknowledges the commitment of the Ministry, following the recommendations of *He Ara Oranga*, to revise New Zealand's current mental health legislation to give greater recognition to the United Nations Convention for the Rights of Persons with Disabilities (UNCRPD). In particular, the College agrees and applauds the move in Chapter 1 that has a focus on *Taking a Human Rights Approach* as this in in keeping with addressing the inequities faced by people with intellectual and developmental disabilities (IDD) particularly in reference to the respective Articles of the UNCRPD. The College notes that the Mental Health Act may be used with people with intellectual disability, but most clinicians have little training or clinical experience in this area. It is our view that all persons who are involved in the administration of the Mental Health Act must have training in intellectual and developmental disability. Training of DAOs should include a component on application of the MHA with this population. Please note that the abbreviation UNCRPD is commonly used within the sector rather than CRPD as noted in the draft *Guideline*.

The College supports the sections related to te Tiriti o Waitangi (1.1) and consultation with whānau (5.4.2) which are explicit and take into account the kaupapa inquiry (WAI 2575) recommendations. The inclusion of the Mana Enhancing Practice (Te Rau Ora 4.1.1) is supportive of a Māori responsiveness. However, the College believes that training for cultural safety and specific training for all involved in the MHA process when working with Māori and their whānau needs to be more explicit (p.53).

In making this submission we are aware that the new *Guideline* will require a review of the 2012 joint document of the Director and Te Ao Māramatanga New Zealand College of Mental Health Nurses *Guidelines for Mental Health Nursing Assessment*. The College is able to provide this review if funding is available.

The letter from the Director accompanying the draft *Guideline* asks for comments on some specific issues. Comments on these issues are provided below. Before presenting those comments, however, the College wishes to comment on some other issues in the *Guideline*. Dr Crawshaw's letter refers to greater incorporation of patient-centred models of care, supported decision making, improved family/whanau consultations and greater cultural responsiveness. Based on *He Ara Oranga* and responses from members to this draft document we have identified some additional issues that are apparent in the draft. These are:

- New Zealand's high rate of use of compulsory treatment orders.
- The marked disparity of use of community treatment orders with Maori compared to non-Maori.
- Issues related to the United Nations Convention for the Rights of Persons with Disabilities (UNCRPD).
- Some specific issues in relation to intellectual disability.

These issues are addressed to some extent in the draft *Guideline*.

Apart from some questions about details of the *Guideline* there are some substantive issues that we would like to see addressed before the *Guideline* is finalised. These are related to advice to clinicians about recommencing compulsory treatment (page 70) and consent (page 77). It is our view that the Guideline could be strengthened in its messages to clinicians around least restrictive interventions and maximizing autonomy to the greatest extent possible in the circumstances.

There is also scope for the Guideline to use less medicalised language when referring to the process of compulsory assessment. For example, page 1 states that "the Act should be thought of as an entry point to services for people experiencing a mental illness". However, the definition of mental disorder in the Act does not refer to mental illness, but mental disorder. The initial stage of compulsory assessment is about assessment, in other words, making a determination of whether the person has a mental illness or not. Some diagnoses within the DSM require symptoms over a defined period of time. For example, diagnosis of schizophrenia requires a six-month period of symptoms with a month of acute symptoms. We suggest that wherever appropriate term "mental distress" should be used to signal that the Act does not require a diagnosis, or even a mental illness. The concept of mental distress, and how it is different to mental disorder and illness, could be explained in the discussion about the definition of mental disorder on page 14.

In note 26 on page 14, the term “psychopathology” is used to define “abnormality”. We suggest that the term “altered mental functioning” would be more appropriate, taking the view that many acute states are individuals’ survival strategies, and should not be pathologised. The same comment applies to the term “psychopathological abnormalities”. In both cases we would like to see the *Guideline* using less medicalized language.

We question whether it is appropriate to use the term “engagement” on page 38, when the Act speaks about “consultation”. Engagement and consultation are not the same thing. It would be hoped that consultation would be “engaging” and would lead to engagement, but the advice currently suggests that a clinician can “engage”, whereas we suggest engagement is best seen as an outcome of good consultation. The language of the *Guideline* shifts back to consultation on page 39.

Advance directives.

Te Ao Māramatanga- NZCMHNurses is very supportive of the greater recognition given in the draft *Guideline* to the use of advance directives. Advance directives are recognised as one means of giving greater recognition to individual autonomy and the UNCRPD. We suggest that where there is mention of advance directives clinicians could be advised that advance directives could be embedded within recovery plans, rather than being a separate process.

In addition to the references already included we suggest:
Page 12 add a reference to use of advance directives in relation to identifying an appropriate support person.
A reference to advance directives could be included on page 39 (first paragraph). Also, on page 40 in reference to whanau discussion of a treatment plan. An advance directive will likely specify which whanau members should (and shouldn’t) be consulted. There could also be a reference in the second to last paragraph of page 41.
The discussion of advance directives on page 42 should mention that the advance directive could be part of the electronic record.
On page 66 the guidance about the CTO should include reference to an advance directive if there is one in place.
There is another opportunity to recommend using advance directives on page 69, 7.9, in the discussion about release from a CTO (second paragraph).
Consumers may have expressed preferences for or against ECT in their advance directive, and this could be mentioned in section 10.3.1.
Section 11.13.3 provides an opportunity to refer clinicians to advance refusal of medical treatment that might be recorded in an advance directive.
A further bullet point could be added to section 11.4 (page 86) to include providing information about alternative treatments.

Lower threshold for compulsion under CTO (page 66).

Use of compulsion in people with a history of mental illness
On page 70, the *Guideline* notes that a person with a history of mental disorder and well documented early warning signs of relapse may meet the compulsory assessment criteria as soon as those warning signs are detected. This is very permissive advice and signals a highly risk averse approach to relapse management. It is not tempered with any advice about increased support, review of treatment, or any suggestion of alternative approaches. While it seems reasonable to advise that there is no need to wait for *immanent* danger (a criteria that is not in the Act) there should be some guidance to clinicians to consider less restrictive alternatives before invoking compulsory treatment. This advice, and the advice on page 66 (see above) seem to run counter to the general intent of the advice to promote least restrictive alternatives. We have in mind here New Zealand's high rate of use of community treatment orders, and the comments about that in *He Ara Oranga*. The advice should be in terms of the 2 limbs of the Act. It is possible that this very permissive advice could contribute to New Zealand's high use of CTOs. There is a similarly broad interpretation at 7.5.

Consent and assent

Te Ao Māramatanga- NZCMHNurses questions the definition of "consent" used in section 10.1 of the Guideline. In our view this advice is unclear and conflicts with the Medical Council definition of consent given later in that paragraph. Our reading of section 59(2)(a) of the Act is that it implies informed consent, not assent. Section 59(2)(a) refers to consent in accordance with section 67 which states that
"Every patient is entitled to receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side effects, before the treatment is commenced."
Section 67 does not mention assent or make any allowance for coercion in the process of consent. While it is reasonable to acknowledge that informed consent is somewhat constrained when a person is under a compulsory treatment order, we feel the *Guideline* should emphasize, as it does elsewhere, the highest standard of informed consent that is possible in the circumstances, rather than revert to a concept of "assent" which is not in the wording of the Act.

After the sentence "It should not be assumed that a patient who passively acquiesces… course of treatment." It is recommended that the following is added:
As it is often much easier to coerce people with intellectual or developmental disability (IDD) or traumatic brain injury (TBI), acquiescence must be mitigated and checked as this is often an issue for these populations. This can be undertaken by:

- Reversing the wording or reframing the question posed to check for the similarity in response, asking for an example, offering 'don't know' as a response using open-ended questions, allowing sufficient time for a response to be made. This may include a time delay between asking the question and returning to the same line of questioning (in the same or a later session).
- Understanding that assessment and the communication of information in this process cannot occur in a one-off session and may need to be explained multiple times.
- Ensuring the information sought from AND provided to the consumer is facilitated in a format which is appropriate to them such as the language used, Easy Read and/or visual format, translator which may include a sign language interpreter.
- Check the words or common parlance they themselves use in regard to their own health and establish whether they use any form of augmentive communication.
- The above can be aided, and the person supported by someone who knows them well.

- Reasonable adjustments or accommodations need to be made by the health provider and are defined in the UNCRPD as *"necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms"* (Article 2).

A critical consideration also is for people with IDD or TBI is the threshold that is used for capacity to consent/or make treatment related decisions. The ethical and indeed legal assumptions for everyone must presume capacity for decision-making until proven otherwise – so the task then is for the clinician to prove no capacity. As noted in 8.4 where reference is made to the Code of Rights (Right 7[2]). This is also relevant to Advance Directives section.

Practical issues with the proposed changes and suggestions for resolution.

6.3 Application for assessment.
The first sentence of this paragraph is potentially confusing, as it appears to suggest that the section 8B certificate must be completed prior to the section 8A application. The confusion arises because 'application' means the section 8A application form AND the complete application process (including both the 8A form and 8B certificate). This could be avoided by firstly stating that completion of the 8B certificate normally follows completion of the 8A application *form*. Also please note this paragraph states that the 8B certificate must be completed within the 3 days prior to the date of the 8A application. This should read "within 3 days of the date of the section 8A application". We ask that this advice is further reviewed. On some occasions the 8A application is completed after the 8B.

A similar issue to that outlined above occurs on page 50. The advice there also seems to confuse the section 8A application form with the section 8 application process (which needs both the 8a and the 8B). The advice states that the section 8A application can only be made after the section 8B certificate has been completed. But this reverses the usual (and presumably intended) order, where the 8A is completed first. Our suggestion is that this section is reworded so that it is clear that the 8A is normally completed first (but as noted above, not always) leading to the 8B certificate.

The advice around section 8 application may need to include a comment on how the practice setting and urgency might impact on the process, with the order of 8A and 8B differing while still in compliance with the legislation.

p.35 Section 3.2 Intellectual Disability
Delete the second bullet point and replace with:

- persons with intellectual disability may develop dementia at an earlier age than the general population – this includes but is not limited to those with Down Syndrome.
- people with intellectual disability may experience a greater prevalence of a range of mental disorders compared to the general population

The risk of diagnostic overshadowing must be assessed in this population as changes in one's usual presentation may be deemed 'behavioural' and/or as indicative of a mental illness and may mask a physical cause.
Also please add:
Clarification is needed in reference to the application of the ID(CC&R) Act: there is a misconception that people may be detained under the ID(CC&R) Act purely on the basis of the risk of harm they pose to themselves or others and this is ethically, legally and clinically not the case.
The ID(CC&R) Act (2003) can ***only*** be considered if someone with an intellectual disability has been charged with (and found unfit to stand trial) or convicted of, an imprisonable offence.

Is the cultural responsiveness sufficiently addressed?

Some comments provided on page 1 about this.

Are cultural models of care accurately described?

Some comments provided on page 1 about this.

Are the principles of Te Tiriti o Waitangi appropriately applied?

Some comments provided on page 1 about this.

Is gender identity appropriately described?

Yes.

Are co-existing mental health and addiction experiences in the context of the provisions of the Act suitably incorporated and acknowledged?

In general, yes.

Other matters

It would be helpful on page 37 to include a comment on the role of interpreters who are also clinicians with the mental health service. Sometimes clinicians who speak the patient's first language act as interpreters, and it would helpful to acknowledge this and mention any issues that these clinicians should consider.

On some occasions a DAO or another clinician may have discussions with a whanau member about use of the Act. Can the RC's obligation to consult be "delegated" in whole or in part? A statement about this would be helpful.

Section 2.4. We question whether it is correct to say that the principal caregiver is "appointed". It seems more correct to say the principal caregiver is nominated by the patient. A reference to advance directives here would be helpful as there may be someone nominated as the patient's preferred contact person.

Some issues of wording raised for clarification.

The advice on page 51 needs to be clearer (third bullet point) about whether this examination is actually a "medical" examination (under section 9) or a health professional examination under section 8B.
Section 6.4.4. Some senior registrars do complete section 9 assessments. As do MOSSes.

We question the use of the term "gravely" one page 1, as this term is not used in the Act.
Page 2 should say the Office of the Director…IS available….
Page 4 should read … "and self-harm) *disability* and alcohol…."
Page 6 should read "for people who require support in expressing their will and preferences" (rather than "another person"). With support the person may be able to express their preferences themselves, which is the idea of supported decision making.
Page 15 refers to "certainty" that a person will become unwell again. While acknowledging that the intent is to set a high bar for use of compulsion, an intent we support, "certainty" appears to be too high, and if applied rigorously might exclude some people from the protective intent of the Act.
Page 16, "the law in this area as unsettled" should read "IS unsettled".
Page 17, it would be useful to note that the impulse to self-harm often occurs in the context of acute distress and may resolve if the person is provided with support. This would be useful guidance to a clinician in an emergency department who is asked to assess someone presenting with acute self-harm.
Page 21 "posed" should probably be "possessed".
Page 22, we question the use of the term "proper" (social relationships) as it seems somewhat judgmental. We suggest "satisfying" or "productive" or some similar term.
Page 23. The wording "…they must meet both criteria" is potentially confusing as it follows immediately after a reference to "both limbs". We suggest "the criteria for both mental disorder and safety" (or similar wording).
Page 27 regarding section 4(d) should read "discussed *above* at 2.1".
In the paragraph (3.1) describing suicidality in intoxicated persons, we think it would be helpful add to the first paragraph, a clarification that an intoxicated person who expresses suicidal intent may no longer express that intent when free of the influence of the intoxicant. We also think it would be helpful to provide some guidance as to whether use of the Act is preferable to medical treatment under duty of care for a with a suspected delirium secondary to substance use, for example opioids.
Page 30 gives an example of Down Syndrome and dementia as an example of dual diagnosis. However, in relation to the Act this may not be the most helpful example as it is less likely to present

acutely. An example of DS and psychosis NOS or depression with psychotic features would be more appropriate. We also suggest the word “beneficial” is replaced with “important” in this section.
Page 35. We suggest “medical care” would include medical and surgical care.
The sentence on page 41 regarding capacity in relation to identifying whanau to be consulted is not clear. It is not clear what “differs” means in this context. This sentence could be amended to refer to the nominated whanau in an advance directive, if there is one.
Page 44 we suggest the wording (para 2) “However the clinician may decide, given the urgency it is not in the best interest…”
Page 45 suggest the wording “A health practitioner should not solely make decisions….”
Page 45 “Tino rangatiratanga, which shares tie with …”
Page 47 ‘advanced directive’ should be “advance directive”
Page 50 “supportive” should be “supported”.
Page 51 the wording “on suspicion that they may be mentally disordered..” has a criminal connotation and should be change to “on the basis of a belief that…”. A similar issue arises on page 106 where the wording “believes” could replace “suspects”.
On page 52 the terms “free” and “release” are used interchangeably. The Act speaks of “release”.
Page 52. The first box should refer to 8B4b.
Page 54 should read “…accompanied BY an appropriate person”.
Page 55. The term “assessor” is used (last para). Does this refer to the mental health clinician at section 9/10?

p.58 Section 6.1 Role of DAO

para 2 Add:
Refer to Section 10 – Consent includes interpretation and communication as the recommendations pertaining to engaging, communicating and application of the MH Act apply also here in regard to the role of the DAO.

Within section 6.4.4 the term “psychiatrist” has not been consistently replaced by “health practitioner”.
Section 6.6 “tangi” should be bracketed with “funeral”.
Page 80, the wording “to endorse any good practice treatment” is awkward.
The document twice refers to “registered mental health nurses” (page 59). This should be changed to “registered nurse”. There is no registered mental health nurse in New Zealand.
On page 82, second bullet point, that wording “…may also be involved…”should be amended to “…should also be involved”.
On page 97, the term “District Inspector of Mental Health” should be “district inspector”.

p.98 Rights

Every person should have their rights explained to them in a way that they are most likely to understand, with an appropriate support person present if necessary. This is an ongoing obligation.
Page 105 should refer to a health practitioner rather than a medical practitioner.
The references on page 106 to “psychiatric units” should be replaced with “mental health units”.
The first sentence of the second paragraph in section 11.5 is unclear.
Use of whānau and family is not currently consistent throughout the document.

In conclusion, Te Ao Māramatanga- NZCMH Nurses supports the implementation of this updated *Guideline* and looks further to further consultation on development of new mental health legislation.

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