

Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992

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Introduction

These guidelines are intended to support the effective and lawful use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (referred to hereafter as ‘the Act’ or ‘the MH(CAT) Act’). The purposes of the Act may be described as being to:

- define the circumstances in which compulsory assessment and treatment may occur
- ensure that both vulnerable individuals and the public are protected from harm
- ensure that the rights of patients and proposed patients are protected
- ensure that assessment and treatment occur in the least restrictive manner consistent with safety
- provide a legal framework consistent with good clinical practice
- promote accountability for actions taken under the Act.

The Act is not a comprehensive framework for mental health treatment. It should instead be thought of as an entry point to services for people experiencing a mental illness which causes or may cause serious harm to themselves or others. Compulsory treatment under the Act provides an opportunity for a person experiencing a serious mental illness to begin to live well in the community and take self-ownership of their health care. This is promoted through a focus on regular collaborative consultation between compulsory patients and clinicians, and the statutory presumption in favour of minimally restrictive treatment in the community.

No piece of legislation can be framed in such a way that all circumstances that can possibly arise are precisely covered. If there is uncertainty as to the ‘correct’ interpretation, any action taken should be taken in good faith, be consistent with the spirit and intent of the Act, and reflect best clinical practice. In practice, especially in urgent circumstances, situations may arise where adherence to a literal interpretation of the Act may compromise the safety and wellbeing of the individual, staff or public. If the Act can be interpreted in two ways, literally or purposively (that is, in a manner consistent with its purpose), then the purposive interpretation should be preferred.

The Act gives specific powers to enable compulsory assessment and treatment to occur and in limited circumstances permits the use of reasonable force in exercising such powers. A clinician, member of the Police or any other person should be able to justify their actions in terms of the powers conferred by this Act or other legislation or authority.

The Ministry of Health has issued a range of guidance material to assist clinicians and administrators to best fulfil their statutory roles, and to assist in the appointment of suitable candidates to statutory roles. The following guidance documents should be read in conjunction with these guidelines:

- *Guidelines for the Role and Function of Directors of Area Mental Health Services* (Ministry of Health 2012)
- *Guidelines for the Role and Function of Duly Authorised Officers* (Ministry of Health 2012)
- *Competencies for the Role and Function of Responsible Clinicians under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2001)
- *Guidelines for Medical Practitioners using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health 2000).

A full list of related Ministry of Health publications is contained in Appendix 1.

1 Section 2: Definitions

1.1 ‘Mental disorder’

Mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it –

- (a) poses a serious danger to the health or safety of that person or of others; or
- (b) seriously diminishes the capacity of that person to take care of himself or herself; –

and **mentally disordered**, in relation to any such person, has a corresponding meaning.¹

The central criteria for initiating and continuing compulsory assessment and treatment is that a person is or appears to be *mentally disordered*. The Court of Appeal discussed the definition of ‘mental disorder’ at length in its decision in *Waitemata Health v Attorney-General*.² The following general points can be inferred from that case.

- The definition of ‘mental disorder’ is based on phenomena rather than diagnosis.³ The Act avoids reference to any particular mental or psychiatric illness. Instead, it provides a number of symptom clusters that might indicate an ‘abnormal state of mind’. These are ‘delusions, or disorders of mood or perception or volition or cognition’.
- The language of the ‘mental disorder’ definition seeks to avoid the debate over the difference between mental illness and behavioural disorders. A person with a severe personality disorder exhibiting any of the phenomena identified in the ‘mental disorder’ definition may well qualify for compulsory treatment under the Act, despite not having a mental illness according to clinical definitions.

¹ Section 2(1) of the MH(CAT) Act.

² (2001) 21 FRNZ 216; [2001] NZFLR 1122.

³ ‘Phenomena’ are abnormalities of specific areas of mental functioning (psychopathology) that may be observed. The presence of individual abnormal phenomena does not necessarily indicate a specific illness or diagnosis. ‘Diagnosis’ is an attempt to identify an illness, based not only on the presence of patterns of psychopathological abnormalities, but also on the basis of the cause (aetiology), time course (history) and outcome (prognosis) of the disorder. Diagnosis may be relevant to the definition in terms of assessing whether the disorder of mind is of a continuous or intermittent nature (for a fuller account refer to Dawson J. 1996. Psychopathology and Civil Commitment Criteria. *Medical Law Review*. 4: 62–83).

The part of the definition of 'mental disorder' concerning the nature of a person's abnormal state of mind, ending with the word 'cognition', is commonly referred to as the 'first limb' of the definition. The part of the definition concerning the severity of the person's condition is referred to as the 'second limb'.

1.1.1 'Abnormal state of mind'

Whether or not a person has an 'abnormal state of mind' is determined wholly by the presence of one or more of the phenomena provided in the 'mental disorder' definition. Clinicians should not measure whether, taken as a whole, a person has an objectively abnormal state of mind compared with that of the average person, but whether any phenomena indicating an abnormal state of mind as described at 1.1.3 are present.

1.1.2 'Whether of a continuous or an intermittent nature'

The definition of 'mental disorder' specifically includes intermittent disorders. This reflects an allowance for a fluctuating intensity of the phenomena characterising an abnormal state of mind. Remission and relapse of phenomena may occur during the course of a person's recovery. There is no requirement that the phenomena on which the finding of mental disorder is based must necessarily be present at the time of examination, or at the time that the application is made. There are times when it may be appropriate to continue or even initiate compulsory treatment during a period of remission. Compulsory treatment may be appropriate in some cases for a person who appears to currently be well if the person has previously demonstrated:

- repeated or prolonged episodes of illness
- severe consequences during phases of illness, such as severe violence to self or others
- early loss of insight during an episode of illness, with a pattern of failing to be able to take the necessary steps to halt the development of illness
- changeable insight into the nature of their mental illness that results in an inability to maintain a consistent decision to seek appropriate treatment.

The definition of mental disorder incorporates intermittently present phenomena, allowing continuing compulsory treatment during periods of remission to provide for more intensive overview and the possibility of early intervention to prevent relapse.

1.1.3 ‘Characterised by delusions, or by disorders of mood or perception or volition or cognition’

An abnormal state of mind must be characterised by one or more of these phenomena. These may be abnormal for the individual, compared to what is normal for the individual (as is the case in an acute illness, for example), or abnormal in terms of population norms.

Particular care must be taken to ensure that the state of mind is ‘abnormal’ in terms of the individual’s cultural norms. These may include Māori spiritual beliefs or other belief systems. For example, in *Re MMG*,⁴ the applicant believed in witchcraft and was a member of a community of witches, which included the applicant’s mother.

The Court of Appeal in *Waitemata Health* described in passing the phenomena in the definition of ‘mental disorder’ as words in ordinary use, although their application is heavily dependent upon the assessment of clinicians. This means that colloquial uses of those words are not sufficient to bring someone under the Act, but that phenomena are not strictly limited to their clinical definitions. For example, when a person is described as ‘deluded’ in the ordinary use of that term, it does not follow that the person has ‘delusions’ for the purposes of the Act. However, the Court suggested that a severe personality disorder that led to an exceptionally disturbed view of the world could feasibly be taken to be a disorder of cognition or perception.⁵

This has been followed in some subsequent cases⁶ but questioned in others.⁷ It should be noted that the ‘mental disorder’ definition was not directly at issue in the *Waitemata Health* case, and so the Court’s statements are advisory and not strictly binding. The Ministry regards the law in this area as unsettled, and cautions against undue expansion of the psychiatric understanding of the disorders that can give rise to an abnormal state of mind.

Several of the phenomena described in the mental disorder definition – delusions, disorders of mood and disorders of perception – are well-defined clinical concepts. The concepts of ‘disorder of volition’ and ‘disorder of cognition’ are not well-defined clinically and are open to interpretation, as explained below. The following explanations are intended to provide guidance.

⁴ *Re MMG* (NMHRT 568/98), 18 November 1998. The Mental Health Review Tribunal (MHRT) considered the applicant’s beliefs this factor, but the applicant was nevertheless considered to have fulfilled the criteria of the first limb of the mental disorder definition.

⁵ *Waitemata Health* at [72].

⁶ For example, in a later case concerning Mr H (*Re RCH* [2002] NZFLR 413), the Mental Health Review Tribunal (MHRT) accepted the view that H’s severe personality disorder created overvalued ideas to the extent that it constituted a disorder of cognition. In *Re GTL* (MHRT 11/094, 7 December 2011) aspects of a person’s severe personality disorder were considered disorders of mood, volition and perception.

⁷ See *Re RCH* (MHRT 12/039, 30 April 2012).

Disorders of volition

'Volition' means the power to consciously choose or will, and includes the power to act on or abstain from acting on that choice or will.⁸

A disorder of volition may include:

- catatonic excitement or withdrawal
- depressive stupor
- passivity phenomena and command hallucinations
- amotivational syndrome in major psychosis.

These are examples of absent or changed volition that occur in the context of a major mental illness. Rare states such as conversion disorders, sleep walking and epileptic automatism may also be disorders of volition.

There are many other circumstances where volition may be seen as abnormal. These are within the areas of disorders of impulse control. Here, a person is aware of their actions and potential outcomes and has normal reality testing, but acts according to an impulse or desire for some reason. One of the difficulties here is the conflict between an irresistible impulse and an impulse not resisted. It is extremely difficult to judge clinically whether someone is able to resist an urge, but chooses not to, or is truly unable to resist. Whether these should be included as disorders of volition is, therefore, arguable. Examples of mental illnesses involving impulse control include:

- obsessive compulsive disorder
- eating disorders
- impulsive states (for example, in borderline personality disorder or attention deficit disorder)
- psychosexual disorders (for example, paedophilia)
- kleptomania/pyromania
- pathological gambling.

It is the uncertainty of the group of illnesses listed above that gives rise to one of the largest potential abuses in the definition of mental disorder. Because the term 'disorder of volition' is not one that is generally used in psychiatry, its interpretation is difficult. Moreover, the *Diagnostic and Statistical Manual of Mental Disorders* refers to all the behaviours it describes as 'disorders', although many are clearly not 'mental disorders' that could be subject to compulsory treatment under the Act. These factors result in confusion about how the legal term 'disorder of volition' should appropriately be applied to clinical situations. Many psychiatrists feel that obsessive compulsive states and eating disorders may be compulsorily treated if volitional control is reduced.

⁸ *Dorland's Illustrated Medical Dictionary* (32nd ed 2012), *Mosby's Dictionary of Medicine, Nursing and Health Professions* (1st Australian and New Zealand ed 2006).

There is a presumption that every person has the right to choose and the right to take responsibility for the outcomes of their choices. Compulsory intervention can only be justified when a person is affected by a condition that impairs or affects their ability to choose, with serious or dangerous consequences. In general, conditions such as psychosexual disorders and anti-social personality disorder will not be considered an abnormal state of mind, unless particularly severe or complicated by another condition such as a disorder of mood, perception or cognition, delusions or intellectual disability.

Disorders of cognition

‘Cognition’ includes the processes involved in perceiving, knowing, recalling, thinking, learning, evaluating and understanding, and includes the mental process of obtaining, organising and utilising sensory and perceptual information, remembering past experiences, and making plans or strategies.⁹

‘Cognition’ can also refer to a thought. The potential difficulties with the use of the term ‘disorder of cognition’ are primarily the confusion between cognition as a process and cognition as a thought. It is inappropriate to define ‘cognition’ as a thought rather than a process to include people with deviant but non-delusional thoughts in the scope of the Act. If cognition is seen as the process of thinking, perceiving and recalling, then the use of this concept should not spread excessively beyond that intended by Parliament.

Disorders of cognition clearly include:

- slowing of cognition in depressive states
- increased rate of cognition in manic states
- disorganisation or disruption of thought process in psychotic states
- cognitive changes in dementia and other acquired organic mental disorders.

A disorder of cognition can be seen to embrace the thought disorder commonly noted during psychosis, namely disorganised or illogical thought processes of a very severe degree, as well as poverty of thought or absence of thought that can occur in some marked psychotic states. As the terminology has been different (‘cognition’ versus ‘thought’), some psychiatrists have been uncertain whether formal thought disorder is embraced by a disorder of cognition. In the Ministry’s view it is. Formal thought disorder may be the only mental state abnormality in some manifestations of psychosis. It may also cover:

- obsessional rumination in obsessive compulsive disorder
- disordered self-perception such as in eating disorders
- anxiety disorders with recurrent ruminations.

⁹ *Dorland's Illustrated Medical Dictionary* (32nd ed 2012), *Mosby's Dictionary of Medicine, Nursing and Health Professions* (1st Australian and New Zealand ed 2006).

It is rarely appropriate to compulsorily treat conditions characterised only by recurrent dangerous thoughts such as inappropriate sexual desires or violent fantasies. To be compulsorily treated, such conditions should be characterised by a lack of control over acting on such thoughts of such severity as to constitute a disorder of *volition*. Without such a volitional disorder, such persons will rarely present a sufficient danger to the safety of others to satisfy the definition of mental disorder.

Intellect is clearly a component of cognition. Intellectual disability can be seen as a disorder of cognition for the purpose of section 2 of the Act. However, section 4(e) of the Act qualifies this by stating that Parts I and II of the Act shall not be invoked in respect of any person by reason only of intellectual disability.

Personality disorder

Individuals with personality disorders are neither specifically included in nor excluded from the provisions of the Act, because the Act is couched in terms of clinical phenomena rather than in terms of diagnosis. Individuals who display the phenomena covered by the definition of mental disorder, which will include some individuals with certain types of personality disorder, may be brought within the scope of the Act when necessary.

1.1.4 ‘Of such a degree that’

The first limb of the ‘mental disorder’ definition must give rise to the second limb. A person might both have an abnormal state of mind, and pose a significant danger to self or others, but will not be mentally disordered unless the abnormal state of mind actually causes the person’s dangerousness or diminished capacity for self-care.

1.1.5 ‘Poses a serious danger to the health or safety of that person or of others’

The following elements may be useful in conducting a risk assessment to determine whether a ‘serious danger’ is posed:

- nature of the harm
- magnitude of the harm
- imminence of the harm
- frequency of the harm.

These criteria need not all be met to a high level for a serious danger to be posed. The nature and magnitude of the potential harm posed by a person may be low, but the frequency at which this harm is exhibited may be high enough to amount to serious danger if, for example, the person is engaging in repetitive harmful behaviour as a result of an abnormal state of mind. Likewise, a person may have committed one or two violent acts as the result of an abnormal state of mind, but remain a serious danger to others due to the severe nature of the potential harm. The following criteria may also help in determining whether ‘serious danger’ is posed:

- situational circumstances and conditions that affect the likelihood of harm occurring
- balancing the potential for harm against the nature of the proposed intervention.

Serious danger to the safety of others will normally involve the prospect of violence by the person towards others, but includes other acts likely to increase the risk of injury to others, for example, loosening the bolts on a car's wheels.¹⁰

Serious danger to the safety of the person in question may arise if a person's argumentative or confrontational demeanour, which is a result of an abnormal state of mind, makes the person likely to be the victim of violence from others.¹¹ It may also arise if a particularly vulnerable person has a history of being sexually exploited when affected by an abnormal state of mind.¹² There may also be a serious danger to the safety of a person if an abnormal state of mind leads to suicidal ideation.

When considering a serious danger to the health of others, both physical and psychological health should be considered.¹³ A person with an erotomaniac fixation might constitute a serious danger to the mental health of others. In *Re IC*,¹⁴ where there was evidence that a person's obsessional attachment and stalking behaviour had caused great anxiety and fear to his victim and her family, but there had been no physical threats, the MHRT held that 'there is clear and unequivocal evidence to show that [the] behaviour poses and continues to pose a serious danger to the psychological health of the victim and her family'. A parent with custody of their child may present a serious danger to the physical or mental health of that child if not subject to compulsory treatment.¹⁵

Serious danger to the health of the person in question may occur if the person has a chronic illness such as diabetes and is unable to manage their condition due to an abnormal state of mind. The clinician should also consider whether the risk of mental health deterioration, as the result of lack of treatment, might constitute a serious danger to the health or safety of the person. Repeated acute bouts of mental illness may contribute to the overall deterioration of that person's condition.

If a person does not have the capacity to make decisions related to their physical health, compulsory treatment under the Act should not be initiated for the purpose of treating physical health problems. The appropriate course of action is to seek a treatment order or an order appointing a welfare guardian under the Protection of Personal and Property Rights Act 1988.

¹⁰ As in *Re MMG* NMHRT 568/98, 18 November 1998.

¹¹ As considered in *Re TRK* MHRT 08/114, 19 August 2008.

¹² *Re JFW* MHRT 11/027, 21 April 2011.

¹³ See *Re RWD* [1995] NZFLR 28.

¹⁴ [1996] NZFLR 562.

¹⁵ *Re TRK*.

1.1.6 'Seriously diminishes the capacity of that person to take care of himself or herself'

Self-care is not limited to the basic necessities of survival (activities of daily living such as food, shelter, hygiene and medication) but includes 'the multiplicity of other needs such as achieving financial security, maintaining proper social relationships, maintaining stable accommodation and seeking out ... the assistance of others ... concerning health and lifestyle'.¹⁶ Self-care has been said to embrace all of 'the higher complexities of modern living'¹⁷ and the 'ability to cope adequately in the community'.¹⁸

Self-care is not simply that which is in the 'best interests' of a person, if they behave in some way that makes them a nuisance to others.¹⁹ Nor does it include provision for 'the capacity to find happiness in life and fulfil potential';²⁰ these are considered to be private and individual matters independent of any mental disorder.

Self-care can also be regarded as those essential functions that can be 'reasonably readily provided or addressed by others'.²¹ The degree of outside care available to a person is a relevant factor in the mental disorder test. If the support of whānau or friends is present to adequately fill the functional gap created by diminished capacity, or to lessen the risks posed to self or others so that they are no longer 'serious', a person who is otherwise mentally disordered may be released from compulsory care.²²

The test of diminished capacity is neither wholly subjective nor wholly objective. A subjective test of diminished capacity may unfairly target people of high economic worth, education or social status. Although that person's capacity for self-care may be seriously diminished by a mental illness, they may still cope adequately in the community. An objective test, on the other hand, may target persons with a below-average capacity independent of any abnormal state of mind, such as those with an intellectual or physical disability, or frailty due to age. In *Re C*,²³ the court described a mixed objective/subjective test of a 'minimum standard of effective self-care for a person of the patient's circumstances and background'.

¹⁶ *Decision 324/95* NMHRT 324/95, 14 June 1995.

¹⁷ *Re AVHMMHRT 08/110*, 25 August 2008.

¹⁸ *Decision 324/95*.

¹⁹ *Re SFC* MHRT 02/032, 4 November 2002

²⁰ *Re AVHM*.

²¹ *Re AVHM*.

²² *Re TRTMHRT 09/078*, 14 August 2009.

²³ DC Auckland, CAT 132/99, 28 August 2000, Thorburn DCJ.

Capacity for self-care is 'unique to the individual having regard to both intrinsic and extrinsic considerations, that is to say, the qualities and characteristics of the individual, together with the features of their social, and material environment'.²⁴ This approach recognises a person's unique skills and talents. Despite this, a certain minimum capacity has been generally considered sufficient in all but the most exceptional cases, as there is a 'broad commonality' between the minimum capacities of most members of the community.²⁵

It is appropriate to primarily enquire as to whether a person meets an objective base-level of capacity for self-care. However, diminished capacity has sometimes been established when a person has feasible goals requiring a high level of functioning, such as running a business,²⁶ working as a doctor²⁷ or attending university.²⁸

1.1.7 Head injury

A person may be compulsorily treated due to a mental disorder arising from a head injury. As mentioned above at 1.1, the definition of mental disorder under the Act is deliberately stated in terms of phenomena rather than diagnoses. The Act requires an abnormal state of mind characterised by one or more phenomena, including 'disorder of cognition'. This applies irrespective of whether the disorder results from a diagnosis of mental illness (in the narrow sense) or any other cause, such as traumatic brain injury, hypoxia, toxicity or dementia.

Section 4 of the Act contains the only reference to diagnosis. This specifically excludes certain conditions (such as intellectual disability) as a sole reason for invoking compulsory assessment procedures. There is no clause in the Act that excludes head injury as the basis of its application.

1.2 'Fit to be released from compulsory status'

The Act defines 'fit to be released from compulsory status' to mean 'no longer mentally disordered and fit to be released from the requirement of assessment or treatment' under the Act.

The Court of Appeal in *Waitemata Health* held that the correct interpretation of this provision was that fitness to be released automatically follows when a person is no longer mentally disordered. If a person remains mentally disordered, it follows that they are therefore not fit to be released.

²⁴ *Re YMHRT 11/139*, 18 January 2012.

²⁵ *Re AVHM*.

²⁶ *Re TJFMHRT 07/037*, 27 April 2007.

²⁷ *Re AEAA MHRT 08/012*, 7 July 2008.

²⁸ *Re AVHM*.

In spite of that interpretation, necessity of compulsory treatment remains a relevant consideration when determining whether a person is mentally disordered. When it is not necessary to maintain a compulsory treatment order, due to good compliance with medication, for example, the severity criteria in the second limb of the mental disorder definition may no longer be met, even if the person's abnormal state of mind is still present under the first limb. The person will therefore be fit to be released from compulsory status.

1.3 'Person in charge'

The Act defines the person in charge of a hospital or a service to be the chief executive officer.

Under section 99B the person in charge of a hospital may delegate their powers under the Act to another person who is suitably qualified, often the Director of Area Mental Health Services (DAMHS). The delegation must be in writing, and any revocation of the delegation must also be in writing. It is recommended that the power to admit or detain a patient or proposed patient only be delegated to a person who has a clinical background, such as members of a psychiatric crisis team and/or designated staff in an acute psychiatric unit.

The authority to admit and detain a patient or proposed patient to a hospital is granted to the person in charge of the hospital under section 113. To avoid any risk of unlawful detention, this authority should be delegated to a person normally present at the hospital.

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 14A(2)(c)) 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 does not affect the clear statutory duty of notification in these circumstances,²⁹ nor does the Health Information Privacy Code or the Code of Health and Disability Services Consumers' Rights (the Code of Rights).

²⁹ See *Re EW*, 24/1/96, Judge McElrea, DC Auckland.

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, their advice as to who the principal caregiver is should be accepted. This information may also have been given in an advance directive. Even if a patient is not competent to choose a principal caregiver, their preferences should be given significant weight.

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

- whether the patient is competent to advise who the principal caregiver is
- who the 'principal caregiver' is for the purposes of the Act.

The DAMHS 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 social 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 more than one principal caregiver may be appointed.³⁰

³⁰ *Re HM* [1999] NZFLR 858.

2 Section 4: Exclusion criteria

Section 4 of the Act prohibits compulsory assessment and treatment by reason only of a person's political, religious or cultural beliefs, their sexual preference, criminal or delinquent behaviour, substance abuse or intellectual disability. However, section 4 does not prohibit assessment and treatment of patients who have a mental disorder but might otherwise fit within one of the section 4 categories. In *Re H*,³¹ Judge Inglis summarised the position.

Once [the Court has found that the patient is mentally disordered within the definition], it is irrelevant for the purposes of parts I and II that the state of the mental disorder exists because the patient is also intellectually disabled. There is no logic in terms of the scheme and purpose of the Act in preventing a person, that is mentally disordered to a degree where a compulsory treatment order is required, from being compulsorily treated merely because the consequences of his mental disorder are heightened by his intellectual disability. The true purpose of section 4(e) is to prevent it being too readily assumed from a state of intellectual disability that there must also be a state of mental disorder *as that term is defined by the statute*. I have italicised the last words to make it clear while intellectual disability may, in its nature, involve some degree of mental disorder in a general sense, it may not involve mental disorder in the specialised statutory sense.

The exclusion factors in section 4 reflect an attempt to indicate the limits of the imposition of compulsory treatment. It is clearly improper for people to be detained in a psychiatric hospital for their political, religious and cultural beliefs, or sexual preference (sections 4(a) and 4(b)).

Compulsory treatment should be confined to those with a major mental disturbance, not a disagreement with the State. This is the rationale for section 4(c) of the Act, which excludes criminal or delinquent behaviour. Conflicts of these types between the individual and society are best reserved for the criminal justice system. Psychiatry's ethical position in the treatment of people experiencing mental illness is undermined if it becomes an agent of State control for groups of people who society may find irksome.

Section 4(d) of the Act, which excludes substance abuse as a sole reason for compulsory assessment and treatment, is discussed below at 2.1. Section 4(e) of the Act excludes the application of the Act on the grounds of intellectual disability alone, and is discussed below at 2.2.

³¹ *Re H [Mental Health]* (1993) 10 FRNZ 422.

Both substance abuse and intellectual disability may contribute to a person's abnormal state of mind. So long as substance abuse or intellectual disability is not the sole cause of a person's abnormal state of mind, an assessing clinician or judge may legitimately consider dangers that arise as a result of any aspect of that person's abnormal state of mind, including dangers that arise due to a person's compulsive substance use or intellectual disability, when determining whether a person is mentally disordered.

2.1 Substance abuse

Section 4(d) of the Act specifically excludes substance abuse as a sole basis for the application of procedures for compulsory assessment and treatment under the Act. But the presence of substance abuse does not preclude the use of the Act if the criteria for 'mental disorder' are otherwise met.

The following are examples of the types of situation in which mental disorder may arise in the context of substance abuse.

- When an intoxicated individual displays suicidal behaviour, or threatens suicide or self-harm, it may be appropriate to utilise the Act. It may be reasonable to form the belief that someone who is threatening suicide or acting in a suicidal manner may be mentally disordered, no matter how intoxicated they are.
- The acute effects of intoxication may present as a mental disorder, for example the effects of hallucinogenic drugs may mimic psychotic symptoms. Persons in such a state will often meet the lower threshold for assessment and treatment under Part 1 of the Act; that is, there will be reasonable grounds to believe that they are mentally disordered until the cause of their symptoms becomes apparent (see 5.1 below).
- Mental disorder may arise as the consequence of long-term substance abuse, for example the cognitive impairment of a Korsakoff's psychosis. If there is a mental disorder, irrespective of its underlying causation, the Act may apply.
- Individuals who have a 'dual-diagnosis' or 'co-morbidity' of a mental disorder and a substance abuse disorder at the same time present particular difficulties for clinical management. An individual who is mentally disordered can be made subject to the provisions of the Act, irrespective of whether they also have a co-existing substance use disorder.

The terms of a community treatment order or leave from an inpatient order, should specify whether abstinence from drugs or alcohol is a condition of the order. The continuing abuse of drugs by an individual who is subject to a compulsory treatment order, particularly if this is associated with disturbance of behaviour, may be sufficient grounds for readmission or reassessment.

The Alcoholism and Drug Addiction Act 1966 provides a legislative basis for compulsorily detaining people in order to treat them for an alcohol or substance dependence problem. That Act should be used if compulsory treatment for such problems is required. Treatment of alcohol or drug abuse should never be the primary reason for compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

2.2 Intellectual disability

Section 4(e) of the Act specifically excludes intellectual disability as a sole basis for the application of procedures for compulsory assessment and treatment under the Act. But the presence of intellectual disability does not preclude the use of the Act if the criteria for 'mental disorder' are otherwise met.

Examples of situations where intellectual disability and mental disorder may concurrently occur include:

- intellectually disabled persons who present a serious danger to the safety of others due to a co-morbid psychosis, and who may be treated under either the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- persons with Down Syndrome who also develop a degenerative mental illness such as dementia.

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 provides a legislative basis for the compulsory care of intellectually disabled persons who have been charged with, or convicted of, an offence. That Act should be considered if compulsory care for such persons is required. When a person with an intellectual disability is also experiencing and being treated for a mental disorder, it will often be beneficial for mental health clinicians to involve clinicians who specialise in the care of intellectually disabled people.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 is not suitable for providing care for people incapacitated solely by an intellectual disability. The Protection of Personal and Property Rights Act 1988 provides a legislative basis for care decisions to be made on behalf of an incapacitated person by a welfare guardian appointed by a court for that purpose, or by an order of a court.

3 Respect for cultural and personal rights

Sections 5 and 6 require powers to be exercised with respect for a person's culture, language and beliefs. The use of the word 'person' in sections 5 and 6 indicates that section 5 applies to all people before they become proposed patients, and once they become proposed patients and patients. The requirements of sections 5 and 6 of the Act mean that staff need to know how to access the services of an interpreter and appropriate cultural advisors, often at short notice. Mental health services should balance their responsibilities under sections 5 and 6 of the Act with the need to ensure that the overall goal of proper care for a patient or proposed patient is not unnecessarily hindered.

3.1 Section 5: Cultural identity

3.1.1 Section 5(2)(a) 'proper recognition of the importance and significance to the person of the person's ties with his or her family, whānau, hapū, iwi, and family group'

Section 5(2)(a) requires that family/whānau relationships be encouraged if they are beneficial to a person's wellbeing. Family/whānau should be encouraged to provide information about the person, in terms of that individual's history, and feedback on any changes noticed when the person is on leave or in the company of family/whānau members. It is important at a very early stage of the compulsory assessment and treatment process to involve family/whānau and to continue to do so throughout the course of treatment.

The relationship between the person and their family/whānau may change over time. A person who refuses contact with family/whānau may change their mind and the wishes of family/whānau should be considered whenever possible (see section 7A).

Note that the Privacy Act does not preclude information from being provided by family/whānau members and does not always prevent family/whānau members and other caregivers from being provided with information about the person³² for example if:

³² See Ministry of Health. 1996, *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services (The Mason Report)*. Wellington: Ministry of Health. Chapter 4.

- disclosure was one of the purposes for which the information was collected³³
- there is a serious and imminent threat of self-harm by the person³⁴
- the person is being discharged into the care of family/whānau.

Clinicians should alert a person's family/whānau about aspects of the person's illness if they are expected to be a part of their support group. For example, clinicians should provide information about the person's medication needs and any kinds of behaviour they should be concerned about.

3.1.2 Section 5(2)(c) 'proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs'

Note that section 65 of the Act affirms that 'every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5'. This requirement is reinforced by Right 1(3) of the Code of Health and Disability Services Consumers' Rights (the Code of Rights). It should be incorporated into the assessment and management of the individual by ensuring that cultural assessment is a key component of assessment.

3.2 Section 6: Use of interpreters

Section 6(2) of the Act requires a court, tribunal, or person exercising any power under the Act to ensure that an interpreter is provided for a person, if practicable, if the first or preferred language of the person is a language other than English. First or preferred languages may include Māori and New Zealand Sign Language, which are both official languages of New Zealand. Appropriate interpreters may also be provided if the person is unable to understand English because of a physical disability.

In practice, section 6(2) of the Act means that the wishes of the person should be sought, particularly prior to any court or tribunal proceeding. It should not be assumed that a person is happy to communicate in English simply because they are able to do so. Section 6(2) of the Act also recognises that people are entitled to choose to communicate in another language. The court, tribunal, or person exercising any power under the Act must also ensure, as far as is reasonably practicable, that the interpreter provided is competent.

When deciding if it is reasonably practicable to provide a competent interpreter, factors to consider include urgency (including the effect of delay on the safety of that person or others) and expense.

³³ See section 6, Principle 11(a) Privacy Act 1993.

³⁴ See section 6, Principle 11(f)(ii) Privacy Act 1993.

Small migrant and refugee communities may pose particular challenges. The Act separates the requirement that an interpreter be sought and the requirement that the interpreter be competent into sections 6(2) and 6(3) respectively. This recognises that sometimes a competent interpreter, whether by accreditation as an interpreter, membership of an industry body (such as the New Zealand Society of Translators and Interpreters), employment as an interpreter, or otherwise will not be available. If it is not reasonably practicable to engage a competent interpreter, an 'amateur' interpreter who is fluent in the person's language and willing to act as an interpreter may still provide assistance to the person.

Section 6(2) of the Act also recognises New Zealand Sign Language as a language. It is important to note that the Deaf community use sign language as their first language and their main source of communication. They see themselves as a distinct culture, and experience unique pressures that affect their mental health.³⁵ Mental health services should be responsive to people, patients and proposed patients who are Deaf by ensuring that a competent interpreter is available to them, and by ensuring that staff members are aware that a Deaf individual's culture surrounding their deafness has specific relevance and meaning.

A registered New Zealand Sign Language interpreter is considered to be a competent interpreter for the Deaf. An updated list of registered New Zealand Sign Language interpreters can be obtained from regional Deaf Association offices or the Sign Language Interpreters Association of New Zealand (SLIANZ).

³⁵ Ministry of Health. 1997. *Moving Forward*. Wellington: Ministry of Health 42–43.

4 Section 7A: Consultation with family/whānau

Section 7A of 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. Comprehensive guidelines for consultation with family and whānau can be found in the Ministry of Health publication *Involving Families: Guidance Notes*.³⁶

The purpose of consultation with family/whānau is to:

- strengthen family/whānau involvement in the compulsory assessment and treatment process
- enhance the family/whānau contribution to the patient or proposed patient's subsequent care
- go some way towards addressing family/whānau concerns about information sharing and treatment options
- help facilitate ongoing family/whānau involvement in MH(CAT) Act processes such as clinical reviews of treatment or court hearings.

When a medical practitioner or responsible clinician is deciding whether family/whānau consultation is in the best interests of the patient or proposed patient, they must first consult the patient or proposed patient. A medical practitioner or responsible clinician must apply the relevant parts of these guidelines when deciding:

- when and how to consult family/whānau or the patient or proposed patient
- whether consultation with family/whānau is reasonably practicable
- whether consultation with family/whānau is in the best interests of the patient or proposed patient.

Consultation with family/whānau is an ongoing process. It is recommended that a medical practitioner or responsible clinician consults or attempts to consult:

- when making significant treatment decisions
- at each juncture in the compulsory assessment and treatment process
- when considering discharge from the compulsory assessment and treatment process
- when developing a relapse prevention plan.

³⁶ Royal Australian and New Zealand College of Psychiatrists. 2000. *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes*. Wellington: Ministry of Health.

Consultation may require the medical practitioner or responsible clinician to disclose a patient's or proposed patient's personal and health information to family/whānau. This is particularly necessary when developing a treatment, discharge or relapse prevention plan in which family/whānau will be involved in maintaining a person's wellness in the community. The disclosure of information for the purposes of consultation under section 7A is not a breach of the Privacy Act 1993 or Health Information Privacy Code.³⁷ However, it is desirable to discuss the consultation process with the patient or proposed patient in advance, so they understand the purpose of consultation and the extent to which information will be shared.

Consultation at the different stages of the compulsory assessment and treatment process is likely to assist the responsible clinician in making decisions at those stages. It may also increase family/whānau awareness of and/or involvement in, and contribution to, court hearings under the Act. If a person has presented to mental health services at a late stage of their illness, when the likelihood of successful consultation has been diminished due to strained family relationships, it may be beneficial to encourage re-engagement with family members as the person becomes well.

The names of family/whānau members consulted should be recorded on the initial assessment record form, and the nature of the consultation recorded in the patient's or proposed patient's clinical file.

The medical practitioner or responsible clinician should obtain a patient's or proposed patient's consent to consult family/whānau whenever possible, but patient consent is not always required, such as when a patient is acutely unwell or lacks capacity to consent. The requirement to consult does not mean a patient or proposed patient forfeits their right to confidential care and treatment. Patients' and proposed patients' rights and the protection of those rights continue to be paramount and a major philosophical tenet of the Act.

The section 7A requirement to consult does not mean all family/whānau concerns about the compulsory assessment and treatment of the patient or proposed patient will necessarily be addressed. It is possible the requirement will raise family/whānau members' expectations about the extent of their role in clinical decision-making and involvement in daily decisions about the care of their family/whānau member. Nevertheless, the requirement to consult should ensure the medical practitioner or responsible clinician makes more informed decisions.

Where family/whānau have been consulted to develop a treatment, discharge or relapse prevention plan in which they will be involved in a person's continuing care, a clinician may share a copy of the plan with those whānau members most closely involved in delivering that care. This is a permitted disclosure of information for the purpose for which it was collected.³⁸

³⁷ See sections 7 and 53 of the Privacy Act 1993.

³⁸ Health Information Privacy Code 1994, rule 11(c).

4.1 Who must consult

Section 7A places the requirement to consult clearly and directly on the medical practitioner or responsible clinician. However, other clinical staff (such as a DAO, care manager or cultural worker) may, because of a pre-existing relationship with the patient or proposed patient and family/whānau, have important roles in facilitating the consultation.

4.2 Who to consult

4.2.1 Defining ‘family/whānau’

Definitions and understandings of family/whānau vary and are informed by different cultural backgrounds and practices. Almost always, the most important perspective for defining family/whānau is that of the patient or proposed patient.

The following definition is only one of many possible definitions, but the Ministry of Health recommends medical practitioners and responsible clinicians use it to help avoid confusion and for consistency across the country.

4.2.2 Recommended definition

‘Family/whānau’ means a set of relationships a patient or proposed patient defines as family/whānau. It is not limited to relationships based on blood ties, and may include any of the following:

- the spouse or partner of the patient or proposed patient
- relatives of the patient or proposed patient
- a mixture of relatives, friends and others in a support network
- only non-relatives of the patient or proposed patient.³⁹

A patient’s or proposed patient’s definition of family/whānau may differ from this recommended definition. If the patient or proposed patient is competent to decide who their family/whānau is, then their definition must be accepted.

The Act requires compulsory notifications at various stages of the assessment and treatment process to welfare guardians and to principal caregivers. Such persons should be regarded as family/whānau for the purposes of consultation under section 7A, in addition to other family/whānau members. Note that ‘principal caregiver’ is more closely defined than family/whānau (see 1.4 above).

³⁹ Royal Australian and New Zealand College of Psychiatrists. 2000. *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes*. Wellington: Ministry of Health.

4.2.3 Prior competently expressed wishes

There are a number of ways in which a patient or proposed patient may have expressed their wishes as to who to consult when they become unable to make decisions, what treatment they do or do not want in such situations, or who can make decisions on their behalf in certain circumstances. These include:

- crisis or treatment plans (see Standard 3.5 of the *Health and Disability Services (Core) Standards – Continuum of service delivery* (NZS 8134.1.3:2008))
- advance directives (see Code of Health and Disability Consumers' Rights)
- enduring power of attorney (see Part 9 of the Protection of Personal and Property Rights Act 1988)
- personal orders under the Protection of Personal and Property Rights Act 1988, including appointment of a welfare guardian.

Clinicians should take steps to give effect to prior competently expressed wishes when reasonably practicable and clinically indicated.

4.2.4 Deciding disputed definitions of family/whānau

In cases of doubt or dispute, the DAMHS is responsible for deciding:

- whether the patient or proposed patient is sufficiently competent to determine who is their family/whānau
- who the patient's or proposed patient's family/whānau is for the purposes of section 7A.

The DAMHS will make this decision based on advice from 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. The DAMHS should consult other knowledgeable parties, for example, the patient's or proposed patient's usual general practitioner, key worker, Māori health worker, kaumātua, cultural support staff, Māori consumer advisory groups, Māori advisory committee, other Māori providers of services to the patient or proposed patient, or a district inspector.

In urgent circumstances, the medical practitioner completing sections 10 and 11 of the Act is responsible for making this decision for the purposes of the Act.

4.3 What consultation is

4.3.1 Definition of ‘consultation’

In practical terms, consultation in this context describes a clinical activity, which seeks to engage family/whānau in a therapeutic process. Consultation is a two-way ongoing process.

Consultation does not require the parties to agree and does not require negotiations towards agreement. However, negotiations and agreement might occur as the tendency in consultation is for the parties to work towards consensus.⁴⁰

Meaningful consultation has been described by the courts to consist of the following stages and may occur in a variety of ways, including in person or by phone (including by teleconference). The party required to consult:

- begins consultation in the formative stages of a process by notifying affected or interested parties of a proposed (not final) decision or action
- provides the affected or interested parties with a reasonable amount of time in which to respond to the notification (which will depend on the urgency of the decision or action)
- may have a working plan in mind that they inform the affected or interested parties about, but must keep an open mind and be ready to change or start afresh should that be required
- provides the affected or interested parties with a reasonable opportunity to form and state their views in a safe and open environment
- considers properly the representations of the affected or interested parties before deciding what will be done
- notifies the affected or interested parties of the outcomes of the consultation.

4.3.2 Deciding about consultation

A medical practitioner or responsible clinician must consult the patient or proposed patient to ascertain their views about consultation with family/whānau. The practitioner or clinician should also give the patient or proposed patient an opportunity to respond to their provisional findings. It is important that a medical practitioner or responsible clinician does not close their mind to alternatives before consultation occurs.

A patient or proposed patient may refuse permission for a medical practitioner or responsible clinician to consult family/whānau. In this situation it is up to the practitioner or clinician to then decide whether consulting family/whānau would be in the best interests of the patient or proposed patient (see 4.5.1 below).

⁴⁰ *Wellington Airport v Air New Zealand* [1993] 1 NZLR 671.

If the circumstances are urgent, a medical practitioner or responsible clinician must still consult with the patient or proposed patient to seek their views about the consultation. However, given the urgency the clinician may decide it is not in the best interests of the patient or proposed patient or not reasonably practicable to consult family/whānau at that time. This does not preclude the practitioner or clinician from communicating with the family/whānau at the earliest possible opportunity after a decision has been made and before further action is taken.

4.4 How to consult

4.4.1 General comment

A medical practitioner or responsible clinician who consults family/whānau must use their discretion to decide how much information to disclose to the family/whānau. The practitioner or clinician must consider how much information the family/whānau needs to make informed and useful responses to the proposed course of assessment or treatment. The practitioner or clinician may have a working plan in mind, but must keep an open mind and be ready to change or start afresh if this is required.

For consultation to be meaningful it must occur before the medical practitioner or responsible clinician makes a decision. Discussions after a decision are no longer consultation but rather information sharing.

Consulting family/whānau as part of the assessment and treatment process is generally ongoing to allow views to change as new information is exchanged. If a significant period has elapsed or new information has come to light since a consultation, the medical practitioner or responsible clinician should not rely on that consultation but consult afresh.

Further consultation may be particularly relevant when the patient moves from the care of one clinician to another. The practitioner or clinician should outline the likely changes and the opportunities family/whānau will have to consult the new clinician or attend future meetings or court hearings.

4.4.2 Māori

Family/whānau involvement will often be important for Māori. As a principal source of strength, support, security and identity, whānau plays a central role in the wellbeing of Māori individually and collectively. The emphasis 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.⁴¹

⁴¹ 'Tangata whai ora' means 'the one who is seeking wellness'.

A medical practitioner or responsible clinician should not make decisions about Māori individual interests and/or whānau interests solely. Whenever possible they should involve Māori health workers, kaumātua, cultural support staff, tangata whai ora advocacy services, Māori advisory committees or other Māori providers of services to tangata whai ora.

To implement section 7A appropriately and to ensure mental health staff work effectively with whānau, staff may need:

- specific training resources
- appropriate cultural expertise
- support within the organisation.

Māori do not all share the same views and practices. Every whānau needs recognition and to be able to participate in care, assessment and treatment processes in a culturally safe environment.

To reduce the risk of inappropriate service delivery and to ensure the patient or proposed patient remains culturally safe, mental health services may need to:

- ensure kaumātua are involved
- seek guidance from appropriate Māori support staff such as Māori health workers, Māori advisory group members or tangata whai ora advocates
- seek advice about tikanga Māori
- train staff in cultural safety
- ensure staff are flexible and responsive.

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.

4.4.3 Other cultures

Similar consideration must be given to the cultural needs of a patient or proposed patient, and their family/whānau, when they identify as a Pacific person or from another culture or ethnicity.

4.5 Reasons for not consulting

4.5.1 ‘Best interests’

The importance of the ‘best interests’ concept is that the interests of the patient or proposed patient come ahead of anybody else’s interests. ‘Best interests’ is an expression used elsewhere in the Act (for example, section 19 and clause 2 of the First Schedule).

The interests of a patient or proposed patient and their family/whānau may conflict. The ‘best interests’ assessment means the medical practitioner or responsible clinician must resolve the conflict in favour of the patient or proposed patient about or for whom they are making a decision.

A medical practitioner or responsible clinician must have reasonable grounds for deciding that consultation with a patient’s or proposed patient’s family/whānau is not in their best interests (under section 7A(3)(b)).

To determine a patient’s or proposed patient’s best interests, a medical practitioner or responsible clinician must consider all relevant clinical or personal information, which includes:

- the mental state of the patient or proposed patient
- the patient’s or proposed patient’s competence to make decisions about their care
- any advance directives the patient or proposed patient may have made
- why the patient or proposed patient wants their family/whānau excluded
- the patient’s or proposed patient’s clinical and family/whānau history
- any previous contact the patient or proposed patient has had with other mental health service providers
- the likelihood of the family/whānau having information not available from other sources.

If family/whānau will be providing the ongoing care of a discharged patient, it will normally be in the patient’s best interests that family/whānau be consulted and have the appropriate treatment information disclosed to them.

If the medical practitioner or responsible clinician decides consulting family/whānau is not in the patient’s or proposed patient’s best interests, they must take into account that:

- they may still seek information from the family/whānau
- the family/whānau may continue to provide information to the practitioner or clinician
- the family/whānau may be given information that was collected for the purpose of being disclosed to the family/whānau

- 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.

4.5.2 ‘Reasonably practicable’

The term ‘reasonably’ brings a measure of objectivity to a decision: with knowledge of the same facts, would a reasonable, responsible clinician make the same decision?

The term ‘practicable’ has been considered in other jurisdictions in relation to family/whānau involvement in mental health care.⁴² It acknowledges that, for various reasons, there are circumstances in which we must be content with less than the ideal, and the degree of compromise calls for judgement and common sense.

Thus when considering whether consultation is ‘not reasonably practicable’ the medical practitioner or responsible clinician needs to consider objectively whether consultation is feasible. They may consider:

- whether the situation is urgent (such as if the patient or proposed patient is acutely unwell and the clinician needs to act quickly)
- the time it will take to contact family/whānau members as well as the time required for family/whānau members to form their views
- any other disadvantage.

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

For assessments occurring after hours, the time of day is not necessarily a reason for not consulting family/whānau. An after-hours assessment would invariably be an urgent assessment and family/whānau consultation may be highly relevant to the immediate safety and risk issues.

Likewise, resource constraints (such as a lack of clinician time) will rarely of themselves justify a ‘not reasonably practicable’ decision. Urgency combined with resource constraints may limit the time available for consultation but will not in most cases make it ‘not reasonably practicable’.

⁴² *R (on the application of E) v Bristol City Council* [2005] EWHC 74 (Admin).

5 Part 1: The compulsory assessment process

If less restrictive mental health interventions have failed, and a person appears to be mentally disordered, compulsory assessment under Part 1 of the Act may be appropriate.

Any person can make an application for assessment under section 8 of the Act, provided they meet the criteria in sections 8A and 8B. However, as the application process is a complex and significant intervention, the Ministry recommends that anyone concerned about a person's mental health contact a crisis assessment team and seek the assistance of a duly authorised officer (DAO). DAOs are appointed to exercise certain powers under the Act relating to the compulsory assessment and treatment of people experiencing mental health issues in the community. The Ministry maintains a list of mental health crisis phone numbers on its website.⁴³

Guidance relating to the exercise of DAO powers, particularly in relation to the compulsory assessment process, is contained in the Ministry of Health publication *Guidelines for the Role and Function of Duly Authorised Officers* (Ministry of Health 2012).

5.1 Threshold for application for compulsory assessment

The Act requires a lower threshold for initial application for compulsory assessment, than for making a compulsory treatment order.

- Under section 8B(4)(b) of the Act, a medical practitioner must 'consider that there are *reasonable grounds* for believing that the person *may be suffering from a mental disorder*' before issuing a medical certificate to accompany an application for compulsory assessment.
- Under section 10 of the Act, the medical practitioner issuing a certificate of preliminary assessment must consider that there are '*reasonable grounds* for believing that the proposed patient *is mentally disordered*'.
- Under section 12 of the Act, the responsible clinician issuing a certificate of further assessment must consider that 'there remain *reasonable grounds* for believing that the patient *is mentally disordered*'.

⁴³ www.health.govt.nz/yourhealth-topics/health-care-services/mental-health-services/crisis-assessment-teams

- Before issuing a certificate of final assessment making an application for a compulsory treatment order under section 14(4), the responsible clinician must consider that a patient '*is not* fit to be released from compulsory status'. Following *Waitemata Health*, this means that the responsible clinician must believe that the patient *is* mentally disordered.
- Before a compulsory treatment order can be issued under section 27(1) of the Act, the court must 'consider whether or not the patient *is* mentally disordered', and under section 27(3) if the court considers that the patient is mentally disordered, it must determine whether or not, having regard to all the circumstances of the case, it is *necessary* to make a compulsory treatment order.

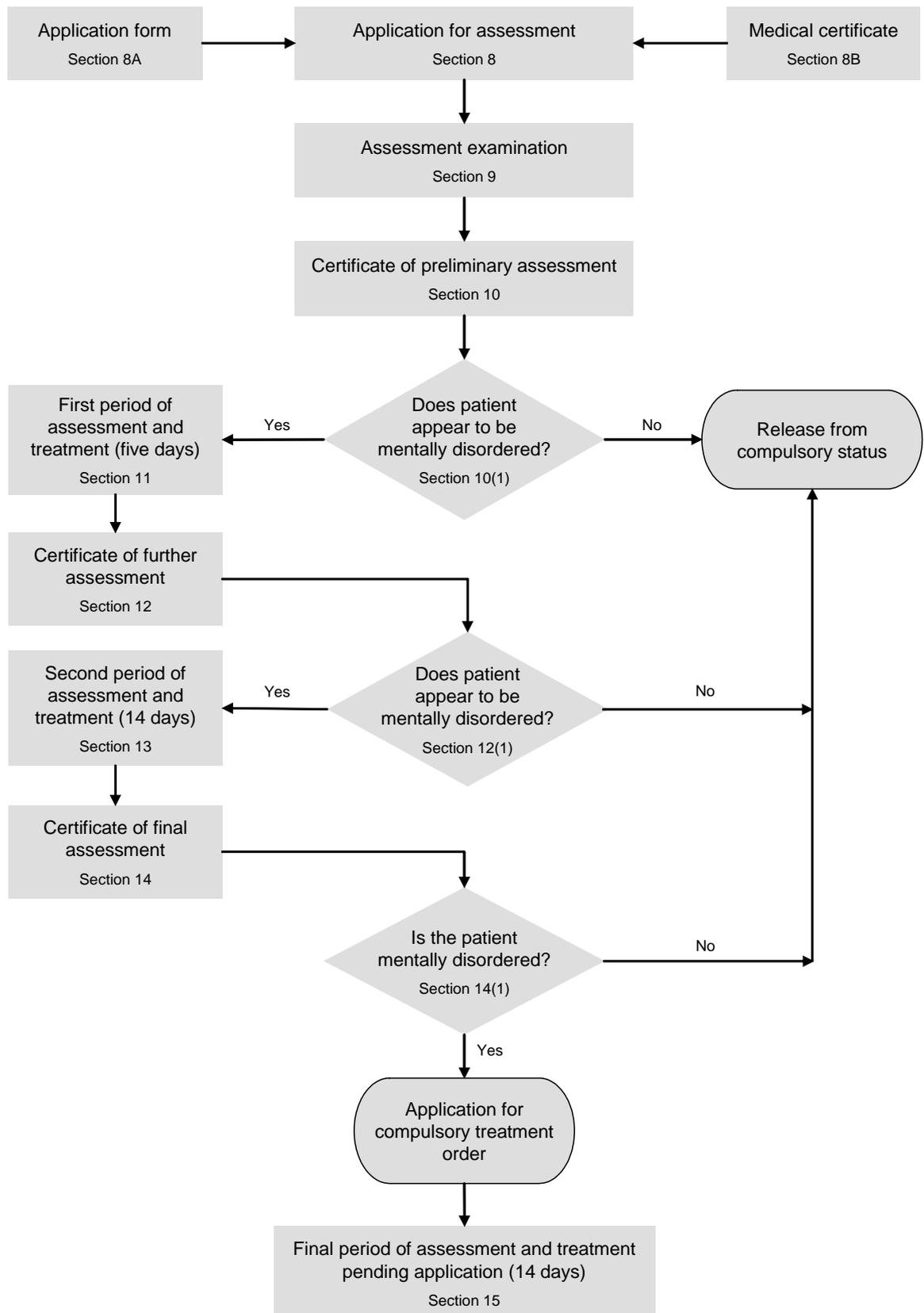
The test of 'reasonable grounds for believing' may be derived both from the responsible clinician's examination of the patient and/or from information given by caregivers, family/whānau and third parties.

The significance of this difference is that whereas there is a high threshold required before a compulsory treatment order can be imposed by the court, including not only the presence of mental disorder but also of the necessity of an order, a clinician can act to invoke compulsory assessment on much less certainty. There is thus the capacity to compulsorily detain and assess in cases when there is some doubt, but if the assessing clinician feels it is prudent to err on the side of caution.

If the responsible clinician becomes concerned at any time that there may have been insufficient grounds for compulsory assessment, the next stage of the compulsory assessment process should be undertaken. A new assessment will cure earlier legal flaws if the validity of the patient's detention is called into question,⁴⁴ therefore preventing a successful application for a writ of habeas corpus.

⁴⁴ *B v Auckland DHB* [2010] NZCA 632; [2011] NZAR 135.

Figure 1: Compulsory assessment and treatment



5.2 Applications for assessment: the role of duly authorised officers

A medical certificate under section 8B of the Act must be obtained before an application for assessment can be completed under section 8A of the Act, although in practice an application will normally be initiated before a section 8B certificate is issued. Once an application is made, a duly authorised officer (DAO) may take all reasonable steps to facilitate an assessment examination under section 40(2)(a).

If no application for assessment has yet been made, and there are reasonable grounds for believing a person may be mentally disordered, under section 38(4)(d)(i) a DAO can take all reasonable steps to take the person to a medical practitioner for an examination if less-restrictive options of facilitating a medical examination have been exhausted.

If necessary, a DAO can under section 41 of the Act request Police assistance to take a proposed patient to a nominated place for the purposes of an examination under section 10 of the Act. Services should refer to the Memorandum of Understanding between the New Zealand Police and the Ministry of Health, which provides guidance to members of the Police and health professionals administering the provisions of the Act, as well as any local agreements made under the Memorandum of Understanding.

More detailed guidance about DAO powers can be found in the Ministry of Health publication *Guidelines for the Role and Function of Duly Authorised Officers* (Ministry of Health 2012).

5.3 Assessment examinations

Section 9(1) of the Act states that the DAMHS or a DAO 'shall make the necessary arrangements for the proposed patient to undergo an assessment examination forthwith'. This means that the DAMHS or DAO *must* take reasonable steps to act on a completed application. Section 9(2) of the Act provides details about these arrangements. This includes a requirement to give the proposed patient a written notice explaining the purpose of the examination and detailing the place, time and the person conducting the examination (section 9(2)(c)).

The DAMHS or DAO may not always be able to perform these functions personally but must ensure that necessary arrangements are made appropriate to the circumstances, including the urgency of the situation. For example, if a medical practitioner is acting under section 110 of the Act (powers of medical practitioner where urgent assessment is required), a phone call to the DAO or DAMHS is sufficient to decide who will carry out the assessment and where. The DAO can ask the medical practitioner to give the section 9(2)(c) notice to the proposed patient and explain what is to occur and their rights (see chapter 11).

Note that written information can be given on any paper, not necessarily the usual form used under section 9 of the Act. In an emergency, the proposed patient should be given as much detail as practicable, but it may not be practicable to give full written details. The clinician must make a reasonable judgement as to how much disclosure is practicable in the circumstances.

In making the necessary arrangements for an assessment examination under section 9(1) of the Act, a DAO may contact other health services (such as a general practitioner) to obtain information relevant to the assessment. The collection of such information by DAOs, and its disclosure to DAOs by health services, is permitted by legislation related to information privacy (the Health Information Privacy Code 1994, the Privacy Act 1993 and the Health Act 1956).⁴⁵

If the proposed patient is assessed as not being mentally disordered, the DAO and other clinical staff of the mental health service concerned should take whatever further action is required to assist the individual who has been assessed. This assistance will normally include:

- the continuing provision of services to a patient who accepts them voluntarily
- assistance with transport from the place of assessment (if the person has been transported to the assessment).

5.3.1 Section 9(2)(d) explanation of notice of assessment

It is mandatory for an explanation of the purpose of the assessment to take place in the presence of a support person under section 9(2)(d). While non-compliance with this section has previously resulted in applications for habeas corpus being granted,⁴⁶ the Court of Appeal has indicated that such a breach is insufficient to warrant nullification of the assessment process by granting the writ if the assessor has attempted to comply with the requirement.⁴⁷

An assessor must offer to organise the attendance of a support person known to the applicant, such as a family member, caregiver or friend, if such a person is available. If no such person is available, an independent person not involved in the application or assessment and treatment process should be engaged. This should not be a mental health professional.

⁴⁵ Section 22F of the Health Act 1956 states that a provider who holds health information must disclose that information to another person who is providing or is to provide health or disability services to a person.

⁴⁶ *Keenan v DAMHS* [2006] 2 NZLR 572; *Chu v District Court at Wellington* [2006] NZAR 707.

⁴⁷ *Sestan v DAMHS, Waitemata District Health Board* [2007] 1 NZLR 767.

Provided this process is undertaken in good faith, it is unlikely to prejudice the validity of the application as other opportunities for clinical and judicial reassessment are available under the Act.⁴⁸ If a proposed patient strongly indicates that they do not want to comply with the requirement, their right to privacy should be respected.⁴⁹ Additionally, there may be situations where it would be unsafe to engage a support person.

5.3.2 Section 9(3) assessment examination to be conducted by a medical practitioner

Section 9(3) of the Act describes the qualifications necessary to perform an assessment examination. The person must be a medical practitioner who is either a psychiatrist approved by the DAMHS or, if no psychiatrist is 'reasonably available', some other medical practitioner who is 'suitably qualified' to conduct the assessment examination in the opinion of the DAMHS.

'Psychiatrist' is defined within section 2 of the Act as 'a medical practitioner whose scope of practice includes psychiatry'. A medical practitioner holding 'scope of practice' in any specialty must have completed vocational training and completed a post-graduate qualification approved for or relevant to the scope of practice.⁵⁰ Registrars are registered in a general scope of practice and do not fall under this definition.

'Reasonably available' is not defined within the Act. The expertise that is 'reasonably available' in a well-staffed urban centre may be very different to that in a more isolated rural area. Nevertheless, some consistency in the matter is expected. When considering the expertise that is 'reasonably available', the following context should be considered:

- who is able to be called
- the geographical location, or how far away the psychiatrist is
- the normal duty roster
- the clinical demands of the situation.

Practically, it may be too onerous for the DAMHS to consider the complexity of all assessments being undertaken, but if a less-experienced practitioner is assessing a case that they (or other members of the multidisciplinary team) feel is complex or particularly fraught, the circumstances and appropriateness of the medical practitioner undertaking this assessment should be discussed with a DAMHS.

⁴⁸ *Sestan*, paragraphs [42]–[55].

⁴⁹ *Sestan*, paragraph [54].

⁵⁰ Medical Council. 2011. 'Scopes of practice'. URL: www.mcnz.org.nz/get-registered/scopes-of-practice (accessed 1 October 2012).

The Ministry considers situations where a psychiatrist would not be reasonably available might include:

- after hours when there is no psychiatrist scheduled on the duty roster (for example in small DHBs where the duty rosters are populated by registrars and Medical Officers (Special Scale))
- when the psychiatrist is absent for other reasons (such as ill health) and cannot be replaced by another psychiatrist
- when the psychiatrist is involved in other urgent work that means they are unable to attend the assessment in a timely manner and they cannot be replaced by another psychiatrist
- when the psychiatrist is too far away to be able to attend the assessment in a timely manner (for example in DHBs which cover a large geographical area).

Whenever possible (and particularly in the last two examples) the medical practitioner conducting the assessment should discuss the particulars of the case over the telephone with the psychiatrist.

‘Suitably qualified’ is not defined, but as a minimum requirement the medical practitioner (such as a psychiatric registrar or medical officer) should have at least two years’ experience in psychiatry. In a more difficult case that requires a fine degree of judgement, a more experienced senior practitioner with a greater level of expertise is needed.

It should be kept in mind that the person in charge of a hospital has the power to detain a person at a hospital for a maximum period of six hours under section 113(1) of the Act. If the proposed patient can be safely detained, it is preferable to detain them until the most suitable practitioner becomes available within a six-hour period.

5.3.3 Reassessment following release from compulsory assessment

Section 10(3) of the Act notes that a further application under section 8A of the Act may be made at some time in the future. There may be circumstances in which a further application is required very soon after the first assessment. There is no time limit specified. A reapplication should be judged on the clinical and other information to hand. It should take into account the previous assessment made under section 10(3) of the Act, and the circumstances of the assessment that found the individual not to be mentally disordered at that time.

5.4 Further assessment and treatment periods

The first and second periods of assessment and treatment are defined in the Act. The first period of assessment and treatment begins on the date that the patient receives a notice under section 11(1) of the Act and ends when five full days have passed, or earlier if the patient is reassessed for the purposes of section 12 of the Act before that date.

The second period of assessment begins when a patient receives the notice under section 13 of the Act and ends when 14 full days have passed, or earlier if the patient is reassessed for the purposes of section 14 of the Act before that date. Following the initial assessment examination, all assessment and treatment decisions will be made by the responsible clinician assigned to the patient by the DAMHS.

Both sections 11 and 13 of the Act refer to the assessment and treatment periods as 'commencing with the date on which the patient receives the notice and ending on the close of the [XX] day after that date'. The five- and 14-day periods should be calculated exclusive of the day on which the notice is given to the patient.⁵¹ It is therefore recommended that the interpretation in the following example be adopted.

Day 0 – The day on which the notice is given to the patient:	1 January
Day 5 – The end of the fifth day:	6 January

This facilitates the management and appropriate assessment of individuals who receive notice of the compulsory assessment late in the day.

If, at any time during the first period (section 11(6)) or second period (section 13(6)), the responsible clinician considers that the patient is not mentally disordered and is therefore fit to be released from compulsory status, they must be immediately discharged. If there are good clinical reasons for truncating the five- or 14-day assessment periods, it is not necessary to let them run their full course.

5.5 Leave during the assessment and treatment process

Sections 11(5) and 13(5) of the Act enable a responsible clinician to allow a patient subject to compulsory inpatient assessment a short period of controlled leave ('trial leave') in the community, or to allow leave on compassionate grounds (such as to attend a tangi). Section 13(5) also applies when a responsible clinician has made an application for a compulsory treatment order.

If the leave is for eight hours or less between 8 am and 10 pm, the Act requires it to be recorded (along with the terms and conditions of leave) in the patient's clinical records (sections 11(5)(a) and 13(5)(a)). The patient's contact details while on leave should also be recorded.

⁵¹ *Re DI* [1996] NZFLR 713.

If overnight leave is granted it must be recorded in the clinical records (as with day leave), and the patient and the person in charge of the hospital must be given a written notice (sections 11(5)(b) and 13(5)(b)).

The written notice should include:

- the day that leave was granted
- length of leave
- when the patient is expected to return from leave
- the patient's contact details
- any terms and conditions attached to the leave.

5.6 Section 14: Certificate of final assessment

Section 14(4) of the Act governs the process of applying to the court for a compulsory treatment order. The opinion that the patient is not fit to be released from compulsory status⁵² must be personally formed by the responsible clinician.

An application for a compulsory treatment order should be accompanied by reports from the responsible clinician and other health professionals involved in the care of the patient. This facilitates the timeliness of hearings and enables the judge to determine whether any further information is required before the date for the hearing is set. A judge is required to consider the evidence of both the responsible clinician and 'at least one other health professional involved in the case' when deciding whether to make a compulsory treatment order (section 18(4)).

A second health professional's evidence should do more than merely address the legal criteria of the Act. It should instead provide a comprehensive global view of the patient's health problems. The second health professional will most often be a registered mental health nurse. Guidance for nurses on report writing is provided in the New Zealand College of Mental Health Nurses publication *Guidelines for Mental Health Nursing Assessment and Reports* (NZCMHN, January 2012) available on the College website (<http://www.nzchmn.org.nz>).

The responsible clinician must primarily address the criteria for compulsory treatment under the Act. The responsible clinician's and other health professionals' reports should collectively include:

- comments on the patient's history of contact with mental health services, including severity of illness and response to treatment
- issues of alcohol and/or drug use
- previous admissions under the Mental Health Act 1969, Mental Health (Compulsory Assessment and Treatment) Act 1992, Criminal Justice Act 1985, Criminal Procedure (Mentally Impaired Persons) Act 2003, Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, or the Alcoholism and Drug Addiction Act 1966

⁵² See *Re LB* [1994] NZFLR 60.

- comments on cultural issues (including advice on whether a cultural assessment has been undertaken)
- advice on family/whānau and social support
- proposals for treatment, including information on community services (if applying for a community compulsory treatment order)
- justification of how the patient comes within the definition of ‘mental disorder’
- any known specific risk issues
- issues likely to be challenged in a defended hearing.⁵³

Other relevant material (such as reports prepared for previous hearings) may also be included. At this stage it should be determined whether or not the patient will require the services of an interpreter.

Following the final assessment, the patient may be held for up to 14 days after the time at which the second period would have expired (section 15(1)). This means that the maximum period for which a person can be held for assessment consists of a five-day first period, a 14-day second period and 14-day final period, totalling 33 days. This period may only be extended by the order of a court (section 15(2)).

5.7 Section 16: Review by a judge

Section 16 of the Act allows the patient to request a judge to review the patient’s condition while the assessment process is in progress. If the judge is ‘satisfied’ that the patient is fit to be released from compulsory status, the judge discharges the patient forthwith and brings the process to an end. If not, the process of assessment continues. Furthermore, it falls to the person seeking the review and seeking discharge to satisfy the judge that the patient is fit to be discharged. In such a review, the judge is unlikely to have available the same amount of evidence as would be obtained at a full hearing. The process outlined in section 16 of the Act can be invoked at any point after a certificate of preliminary assessment requiring further assessment and treatment of the patient has been issued.

A judge has limited discretion in deciding whether or not to grant a review of a patient’s condition. A judge can refuse to grant a review if a patient has had a previous review and there is evidence that there has been no change in the patient’s condition (section 16(1C)).

⁵³ Stephen McCarthy and Dr Sandy Simpson. May–June 1996. *Running a case under the Mental Health Act 1992 and related legislation*. Paper presented at New Zealand Law Society Seminar, pp 14–16.

A judge is required to consider the evidence of both the responsible clinician and 'at least 1 other health professional involved in the case' when determining an application for review (section 16(4)). The second health professional will most often be a registered mental health nurse. Guidance for nurses on report writing is provided at 5.6 above and in the New Zealand College of Mental Health Nurses publication *Guidelines for Mental Health Nursing Assessment and Reports* (NZCMHN, January 2012) available on the College website (www.nzchmn.org.nz).

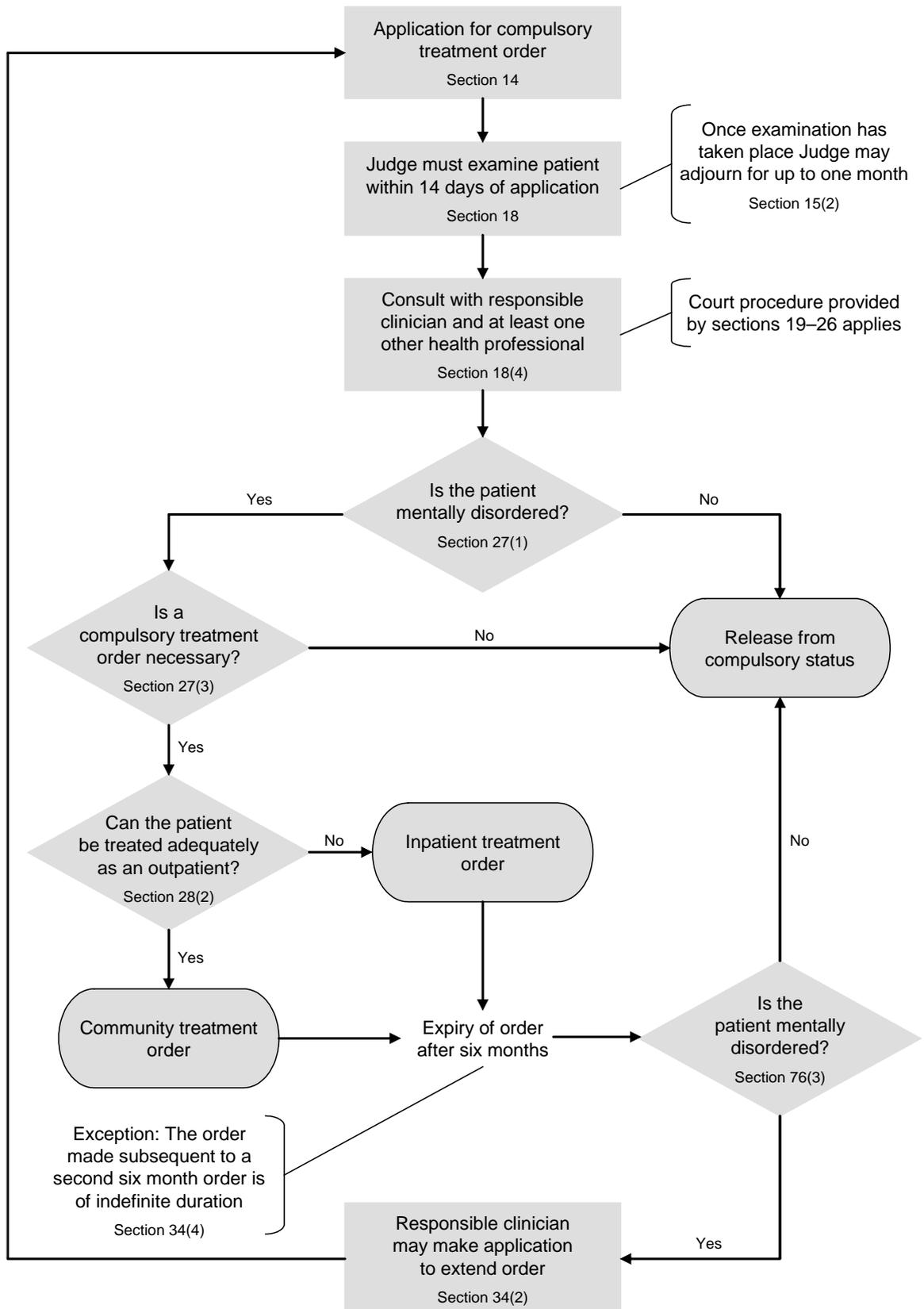
6 Part 2: Compulsory treatment orders

A compulsory treatment order is made by a court under section 28 of the Act. Such an order will only be made when a patient is mentally disordered and the court considers that the order is necessary. This is the only time at which the necessity of an order is considered separately from the question of whether the person is mentally disordered, but necessity of treatment remains relevant to whether or not a person is mentally disordered in other contexts (see 1.2 above).

A compulsory treatment order will be made if the responsible clinician applies to the court under section 14(4), and a Family Court Judge considers that the patient is mentally disordered and that an order is necessary (section 27). An order will be either a community treatment order or, if the patient cannot be adequately treated in the community or is a prisoner, an inpatient treatment order.

This process is outlined in Figure 2 on the following page.

Figure 2: Process for making compulsory treatment orders



6.1 Scope of a community treatment order

'A community treatment order shall require the patient to attend at the patient's place of residence, or at some other place specified in the order, for treatment by employees of the specified institution or service, and to accept that treatment' (section 29(1)).

Treatment is not defined, but must be 'treatment for mental disorder'. Before making such an order, the Court must be satisfied that the patient can be provided with 'care and treatment on an outpatient basis that is appropriate to the needs of the patient' (section 28(4)(a)).

The powers to enforce compliance with the order are outlined in the following sections of the Act.

- Section 29(1): The patient is required to attend and is 'required to accept' treatment for mental disorder at the direction of the responsible clinician during the first month of the community treatment order and thereafter if the patient gives informed and written consent to the treatment (section 59(2)(a)). If consent is not given, treatment may still occur if a psychiatrist (not being the responsible clinician) appointed by the Mental Health Review Tribunal (MHRT) considers that the treatment is in the patient's interests (sections 59(1) and (2)(b); see chapter 10).
- Section 29(2): Employees of the service specified in the order are empowered to enter the specified place for the purpose of treating the patient.
- Section 40(2)(a): A DAO may take 'all reasonable steps' to take the patient to the place where they are required to attend for treatment.
- Section 41(5): The Police may be called to assist and may use necessary force to take the patient to the place where they are required to attend for treatment (see section 122B).
- Section 113A(4)(a): A warrant may be issued authorising Police to take a patient who refuses to attend to the place specified for treatment.

The scope of treatment should be clearly specified in the order (see 6.3). A treatment plan may include a specific residential requirement, but this does not amount to a power to detain at the residence (see 6.2).

It should be noted that, other than under section 29(3)(a), a person who is under a community treatment order can be treated as an inpatient for a period if they consent to such inpatient treatment. Consent should be obtained in writing and can be revoked by the person at any time.

6.2 Residence requirements under community treatment orders

Under a community treatment order, patients are not detained in a hospital or other place as an inpatient unless section 29(3)(a) has been invoked, and patients cannot be required to live at any particular address.

Increasingly, there is a blurred boundary between inpatient and community facilities. For example, community facilities may be planned to provide a high level of care equivalent to that provided in a hospital setting. Although a high degree of supervision may be provided in some residential settings, a community treatment order is not a basis for de facto detention in a community facility. A clear distinction must be maintained between an inpatient order (under which detention in a hospital mental health unit is authorised) and community treatment orders (under which detention is not authorised, except for short periods under section 29(3)(a)).

There is no statutory power for a responsible clinician to direct where a patient must live in the community.⁵⁴ However, a community treatment order made by a judge can specify that part of a patient's treatment can include supervision and monitoring which may only be provided in a particular type of residential facility, although this must not amount to de facto 24-hour detention. Therefore there is a strong need to clearly specify the terms and conditions of a community treatment order (this applies equally to leave for inpatients under section 31) when a responsible clinician applies to a court for such an order.

If clinicians consider that particular arrangements relating to matters other than treatment would be beneficial to a person's recovery, they should attempt to gain the person's informed consent to those arrangements or an order under the Protection of Personal and Property Rights Act 1988 where appropriate.

6.3 Terms of a community treatment order

The Act requires that the place of attendance for treatment and the service or institution whose employees are providing the treatment be specified in the community treatment order. There is no requirement that the treatment be specified. Nevertheless, it is recommended that the application for the treatment order specify the proposed treatment plan, in order that the court may make an order based on a clear plan of treatment.

⁵⁴ *Department of Health v D* (1999) 18 FRNZ 233; [1999] NZFLR 514.

When an application is made, the responsible clinician should state in writing exactly what is sought in the proposed order, setting out:

- the proposed treatment (medication or other treatment) that is considered necessary⁵⁵
- the type/method of treatment as the patient's condition changes
- the location where treatment will take place
- the service(s) or institution(s) responsible for providing the treatment
- monitoring arrangements that will be put in place
- an indication of the services and support that will be available to meet the needs of the patient, additional to those specified as compulsory.

In making the order, the court should specify in writing the conditions of the order in a similar manner. The patient must be given a copy of the order (section 28(5)), which clearly specifies the requirements and conditions of the order.

Non-compliance with the specified terms of a community treatment order may be sufficient grounds to require the use of an enforcement power, an inpatient admission or a reassessment. There is no need to wait for serious danger to self or others, or seriously diminished capacity for self-care, to emerge if a responsible clinician recognises early warning signs of relapse emerging due to non-compliance with treatment.

6.4 Voluntary admissions during the term of a community treatment order

From time to time, a patient subject to a community treatment order may require and consent to an admission to hospital for treatment of their mental disorder as an inpatient. Because prolonged admissions to hospital, even as a voluntary inpatient, may be at odds with the making of an order for community treatment, it may be inappropriate to consider admission for more than a short period. In order to ensure that consent to such an admission is informed and that reassessment under section 29(3) of the Act is used when appropriate, the following requirements should be met.

- An inpatient admission during the term of a community treatment order when the provisions of section 29(3)(a) or (b) do not apply should occur only with the patient's fully informed consent, preferably in writing.
- Whenever a patient is admitted as a voluntary inpatient during the term of a community treatment order, a district inspector must be notified (section 29(6)(d)). The district inspector can then check that the patient consents to the admission.

⁵⁵ If it is likely that there will need to be a variation of treatment during the course of the order, this should be specified as far as possible. It is best not to name particular drugs or dosages, as medication may need to be altered. There needs to be enough flexibility to allow a reasonable degree of change.

- In accordance with the scheme of the Act, which provides for limited compulsory admissions of patients subject to community treatment orders (see 6.5 below), it is suggested that such an admission should normally be for no more than 14 days. After this time, the situation should be reviewed and consideration should be given to either discharging the patient to the community and/or reassessing the patient under section 29(3) of the Act.
- If while the patient is admitted, consent is withdrawn or the patient is sufficiently unable to give consent at any time, consideration should be given as to whether the compulsory assessment and treatment process should recommence.

6.5 Compulsory admissions during the term of a community treatment order

Section 29(3)(a) of the Act permits a responsible clinician to direct that a patient subject to a community treatment order be treated as an inpatient for any one period of up to 14 days without the need to begin the assessment process and nullify the community treatment order. The responsible clinician must first seek to obtain the patient's consent to the inpatient treatment if it is practicable to do so. If the circumstances are urgent and the patient's responsible clinician cannot be contacted, the consultant psychiatrist on call can instruct a DAO over the phone to direct the patient (subject to a community treatment order) to be an inpatient. The form which directs the patient to be an inpatient should be signed by the responsible clinician or the consultant psychiatrist on call as soon as practicable.

If a direction is made under section 29(3)(a) after the first month of the currency of the patient's compulsory treatment order and the patient does not consent to the treatment proposed, the responsible clinician should obtain the opinion of a psychiatrist appointed by the MHRT that the treatment is considered to be in the interests of the patient.

It is not necessary to first obtain the opinion of a psychiatrist appointed by the MHRT that any change in treatment is in the interests of the patient in situations of urgency, if the particular treatment is necessary to save the patient's life or prevent serious damage to their health, or prevent the patient from causing serious injury to self or others (section 62).

A direction for inpatient treatment for any patient on a community treatment order cannot be made more than twice in any six-month period. If a patient requires either one period of more than 14 days or more than two 14-day periods as an inpatient during any six-month period, the responsible clinician must reassess the patient in accordance with sections 13 and 14 of the Act. The two 14-day periods cannot be consecutive.⁵⁶

⁵⁶ *Director of Mental Health Services v Brown* FC Middlemore MA048/156/00 24 October 2000.

When a patient is reassessed under section 29(3)(b) of the Act, the community treatment order ceases to have effect and the assessment proceeds under sections 13 and 14 of the Act.

Both the written notice directing a change to inpatient status under section 29(3)(b) and a section 13 form are required to be completed by a responsible clinician, who must examine the patient. Under sections 58 and 59, the patient must then accept such treatment for mental disorder as the responsible clinician directs.

When a direction is made under either section 29(3)(a) or 29(3)(b) the patient can apply for a review under section 16 of the Act.

6.6 Overseas and domestic travel during the term of a community treatment order

From time to time, patients subject to a community treatment order wish to travel overseas and in some cases will seek the permission of their responsible clinician. The Act is silent on the issue of travel outside New Zealand while subject to a compulsory treatment order. However, in doing so, most patients will be breaching the terms of their order to 'attend a certain place for treatment'. In addition, if a patient becomes unwell while overseas they cannot be treated under the terms of their community treatment order. This can cause considerable distress to the patient and their family, and in some cases results in their repatriation to New Zealand, at considerable cost.

Domestic travel presents similar issues if it would cause a person not to attend at a specified place for treatment.

Depending on a patient's level of acuity or the intensity or frequency of their treatment, it will be sufficient to advise some patients that they are not allowed to travel, and that to do so would breach the terms of their compulsory treatment order. For other patients, it may be worth considering whether an arrangement with another service can be reached to temporarily transfer the patient's compulsory treatment, or whether the person can be discharged from their compulsory treatment order.

6.7 Inpatient treatment orders

An inpatient treatment order requires the continued detention of a patient in a hospital for treatment for a mental disorder (section 30) unless leave is granted under section 31.

An inpatient treatment order can be converted into a community treatment order by the responsible clinician with a written notice under section 30(2), if the clinician considers that the patient can be treated adequately in the community. The place that the patient must attend for treatment should be specified in the notice. Once an inpatient treatment order has been converted into a community treatment order, prolonged compulsory inpatient treatment cannot be restored without a full compulsory reassessment under section 29(3)(b). However, a responsible clinician may direct that up to two non-contiguous 14-day periods of compulsory inpatient treatment occur within any six-month period (section 29(3)(a)).

6.8 Inpatient leave

Section 31 of the Act provides for a patient's responsible clinician to grant leave for a period of up to three months, subject to conditions determined by the responsible clinician. This period may be extended by a further three months.

The Act is unclear about when it is necessary to specify terms and conditions of leave in writing. When practicable, a leave form should be completed in each of the following circumstances:

- when the patient will be on leave overnight or longer
- when leave is being extended
- when there are any doubts about the ability or intention of the patient (and/or the caregivers) to comply with conditions of leave
- if the patient has a history of failing to return to the place of treatment after leave.

The patient and the person in charge of the hospital should also be given a copy of the leave form, similar to the process outlined at 5.5 above.

6.9 Release from compulsory treatment order

Section 64 of the Act requires that patients be kept informed of their legal status, and this should include appropriate written advice of their discharge from compulsory treatment status. Patients should also be given written confirmation if their compulsory treatment status lapses for any reason. It is recommended that release from compulsory treatment status be given in writing and it may be appropriate to use a certificate of clinical review form under section 76 of the Act for this purpose.

Clinicians are permitted to disclose the fact that a person has been or is going to be released from compulsory status to their principal caregiver.⁵⁷ This may be appropriate when the person's family/whānau is expected to be involved in the person's continuing care.

Section 35 provides that, when a person is no longer mentally disordered, they must be released from compulsory status 'forthwith'. Forthwith does not mean instantly, but as soon as reasonably practicable.⁵⁸ It is not justifiable to keep a person who is not mentally disordered under compulsory treatment while lengthy preparations are made for their release into the community; in most cases, release forthwith should occur on the day a person is found fit to be released.

6.10 Reassessment following release from compulsory treatment order

The threshold for reassessing a former compulsory patient for a new term of compulsory treatment will vary depending on the history and circumstances of that person. A person with a long history of mental disorder with well-documented early warning signs of relapse may meet the compulsory assessment criteria as soon as those warning signs are detected. There is no need to wait for imminent danger to arise before reinitiating the procedures of the Act in such a case.⁵⁹ A recent release from compulsory status is not a bar to compulsory reassessment.

If a former compulsory patient is not previously known to a mental health service, or if the early warning signs of relapse are not well-defined, mental disorder may have to be more apparent before the procedures of the Act can be reinstated.

6.11 Extension to compulsory treatment order

A compulsory treatment order will expire after six months unless extended by a judge under section 34. If a responsible clinician thinks that it may be necessary to apply for an extension, they should perform a clinical assessment under section 76 within the last 14 days of a compulsory treatment order. The responsible clinician can then make an application for an extension to the order. Such an application must be lodged with the court before the close of business on the last day of the order. An application for extension is treated as if it is an application under section 14(4).

If granted, an extension will take effect from the date on which the order would otherwise have expired. Where an extension application has been lodged interim provisions allow compulsory treatment to continue under section 15 until the application is determined.

⁵⁷ Rule 11(1)(g), Health Information Privacy Code.

⁵⁸ *Scott v Ministry of Transport* [1983] NZLR 234 at 236, Cooke J.

⁵⁹ *Re KMD* MHRT 04/139, 27 April 2005.

If an extension has been granted, statutory time periods requiring action within a certain time from the making of an order are not reset. For example, section 59(1) requires patients to accept treatment as directed by their responsible clinician within the first month of an order, without consent or a concurring second opinion, but this section does not apply following an extension. Similarly, the requirement under section 76(1)(a) to perform a clinical review within the first three months of an order does not apply following an extension.

7 Part 3: Police and duly authorised officer powers

A duly authorised officer (DAO) is a health professional granted particular powers under the Act by a DAMHS. DAOs must have appropriate training and experience to respond to concerns about a person's mental health and to contribute to the assessment and treatment of people with mental health problems. A DAO will often be the first point of contact for a person with concerns about their own mental health or about someone else who appears to be experiencing a mental health problem.

The exercise of powers under Part 3 of the Act is described in depth in the Ministry of Health publication *Guidelines for the Role and Function of Duly Authorised Officers* (2012), available on the Ministry of Health website.

8 Part 4: Special patients

There are five main categories of special patient defined in section 2 of the Act:

- persons found unfit to stand trial and made a special patient under section 24(2)(a) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CP(MIP) Act)
- persons found not guilty by reason of insanity and made a special patient under section 24(2)(a) of the CP(MIP) Act
- persons found guilty of a charge and both sentenced to a term of imprisonment and detained as a special patient under section 34(1)(a)(i) of the CP(MIP) Act
- remand or sentenced prisoners who require treatment for a mental disorder in a forensic facility under section 45 or 46 of the Act
- persons remanded for a court report, or pending trial or sentencing, under section 23, 35, 38(2)(c) or 44(1) of the CP(MIP) Act or section 184T(3) of the Summary Proceedings Act 1957.

8.1 Right to treatment

Special patients must be given the same care, treatment, training and occupation as they would be given if they were subject to a compulsory treatment order (section 44 of the MH(CAT) Act). This includes the right to 'medical treatment and other health care appropriate to his or her condition' (section 66 of the Act).

8.2 Non-consensual treatment

A special patient (other than a special patient admitted under section 46 of the Act, or detained in hospital under an order pursuant to section 23(2)(b), 35(2)(b) or 38(2)(c) of the CP(MIP) Act) is 'required to accept such treatment for mental disorder as the responsible clinician shall direct' 'during the first month of the currency of the compulsory treatment order' (section 59(1) of the MH(CAT) Act) and thereafter if a psychiatrist (not being the responsible clinician) appointed by the Mental Health Review Tribunal considers that the treatment is in the patient's interests (section 59(2)(b)). In all other cases, a special patient's written informed consent to treatment must be obtained (section 59(2)(a)), except in the case of emergency medical treatment if the patient is unable to consent, or if a prisoner is undergoing compulsory assessment and treatment as a special patient (see section 45(4) of the MH(CAT) Act). Consent is discussed in more depth at 10.2 below.

8.3 Special patients admitted under section 46

Special patients admitted under section 46 of the MH(CAT) Act may only be treated if informed consent has been obtained, like any other person admitted informally to hospital (see the Code of Rights, right 7(1)), except in the case of emergency medical treatment if the patient is unable to consent.

8.4 Special patients detained in hospital for inquiries or assessment under the Criminal Procedure (Mentally Impaired Persons) Act 2003

There are three short-term special patient orders that can be made under the CP(MIP) Act.

- An accused person in custody may be detained in hospital as a special patient pursuant to an order made under section 38(2)(c) for the purpose of a psychiatric examination during any stage of a criminal proceeding.
- After being found not guilty by reason of insanity, or unfit to stand trial, a person may be detained in a hospital as a special patient pursuant to an order made under section 23(2)(b) to determine the most suitable method of dealing with them.
- If a person is convicted, but appears to be suffering a mental impairment, they may also be detained in a hospital as a special patient under section 35(2)(b) to determine the most suitable method of dealing with them.

All of the special patients described above are subject to section 43(1) of the CP(MIP) Act. This provision declares that treatment may only be given to such patients with their consent. If consent is not forthcoming due to incapacity, the DAMHS may authorise any treatment 'immediately necessary' to prevent the serious mental or physical deterioration of the person, or serious suffering by the person, or the person causing harm to self or others (section 43(2)).

The intention of section 43 of the CP(MIP) Act is to prevent routine treatment without consent when a person's legal status has not yet been finally determined through the criminal justice system. As such, this provision overrides the treatment provisions of the MH(CAT) Act. These CP(MIP) Act special patient orders are short-term in nature – sections 23 and 35 orders run for a maximum of 30 days, while section 38 orders may run for up to 14 days – but if a person is obviously mentally disordered and would benefit from compulsory treatment, there is no need to wait for the entire assessment or inquiry period to end before reporting to the court. If a person shows signs of serious deterioration or danger during this time, compulsory treatment is justified under section 43(2) of the CP(MIP) Act.

If a person is detained in a hospital on remand under section 44(1) of the CP(MIP) Act pending a hearing or trial, general provisions applying to the treatment of special patients apply (see 8.2 above and 10 below).

Despite section 43 of the CP (MIP) Act, however, if a person is detained in a hospital under section 23, 35 or 38 it is permissible to begin the process for compulsory assessment and treatment under the MH(CAT) Act (*KR v Capital and Coast DHB HC Wellington CIV-2011-485-700* 19 April 2011, at [24]). It is irrelevant that the person was first detained under the CP(MIP) Act.

It should be noted that under the Code of Rights 'every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the patient is not competent' (right 7(2)). The fact that a defendant is detained under a short-term special patient order does not, in itself, provide reasonable grounds for believing that they are not competent. Furthermore, the Code of Rights notes that an individual with diminished competence 'retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence' (right 7(3)).

8.5 Treatment of prisoners transferred from prison

8.5.1 Section 45

Compulsory treatment for mental disorder in prisoners can only occur within a hospital. If a clinician is considering discharging a person from hospital but considers that the person is unlikely to comply with treatment, a plan should be developed in consultation with the appropriate Corrections liaison to prevent repeated relapses and readmissions.

8.5.2 Section 46

Section 46 of the Act may be used to provide treatment for prisoners who would benefit from mental health treatment. This section requires the consent of the patient, and if appropriate may be used for those individuals who are not mentally disordered, but who would be particularly vulnerable if returned to prison.

A patient treated under section 46 may withdraw their consent. If this occurs, arrangements should be made to transfer the person back to prison as soon as is practicable (section 47(4)). However, if clinicians believe that such a person may be mentally disordered, the clinician should make arrangements for the superintendent of the prison from which the person was transferred to come to the hospital and see the patient with a view to making an application under section 45(2), unless the superintendent has seen the person within the last three days (as required by section 8A(c)).

8.5.3 Treatment while in prison

Treatment may be given to people in prison, with their informed consent. Effective liaison between forensic services and prisons will assist in encouraging patients to continue treatment after returning to prison and enable signs of deterioration to be detected and managed at an early stage. Right 4(5) of the Code of Rights requires cooperation among providers to ensure quality and continuity of services.

8.6 Section 47: Removal of certain special patients back to prison

Section 47 of the Act provides for the Director of Mental Health to approve the transfer back to prison of a patient who has been detained under section 45 of the Act. It also provides for the Director of Mental Health to direct that the patient be returned to prison under section 46 of the Act.

Section 47(3) of the Act notes that the prison concerned must make arrangements for the patient to be returned within seven days after the date on which the direction to transfer is given. It is rare for patients to be detained longer than a day after approval is received, but in such cases they may not be treated without informed consent (except in an emergency), but may be detained in hospital with the authorisation of the prison.

8.7 Leave from hospital

A special patient cannot go outside of a hospital mental health unit on leave without being granted leave by the Director of Mental Health or the Minister of Health.⁶⁰ Special patients are eligible to be granted leave once the criminal justice process relating to their detention has been finally determined.⁶¹ Before leave can be granted, a special patient's clinicians and the Director of Mental Health will make a careful assessment of that patient's risk and balance this with the therapeutic value of leave before making a decision.

8.8 Victim notification requirements for special patients and other forensic patients

Victims of offences committed by special patients and other forensic patients may apply to be notified of significant changes to the treatment of those patients, including leave from hospital and change of legal status. Further guidance around victim notification requirements can be found in the *Victim Notification Guidelines for Directors of Area Mental Health Services and DHB Victim Notification Co-ordinators* (Ministry of Health 2007).

⁶⁰ Sections 50 and 52 MH(CAT) Act.

⁶¹ Section 50(2) MH(CAT) Act.

9 Part 4: Restricted patients

Sections 54 to 56 of the Act deal with the process and effect of a restricted patient order.

Restricted patient status may be imposed on an inpatient who ‘presents special difficulties because of the danger he or she poses to others’ following an application by the Director of Mental Health to the District Court. Such patients must be subject to an inpatient order. Restricted patients need not have entered the mental health services by way of the criminal justice system, but many such patients will have a long history of contact with forensic services, and may have previously been detained as special patients. Restricted patients will be managed by a Regional Forensic Psychiatry Service.

The management of restricted patients is similar to that of special patients. That is, they are not permitted leave without the approval of the Director of Mental Health or the Minister of Health, and the patient cannot be released from restricted patient status solely by their responsible clinician. Because such a high level of restriction is placed on such patients, the reasons for applying for such an order need to be very clear.

Restricted patient orders are a rare and severe limitation on a patient’s rights. If clinicians have concerns that an inpatient in their care may present special difficulties so that management under an inpatient treatment order is not possible, they should discuss the case with their DAMHS. The DAMHS can then refer the case to the Director of Mental Health if appropriate.

10 Part 5: Compulsory treatment

10.1 Recovery planning

The MH(CAT) Act is not a comprehensive framework for mental health treatment. It should instead be thought of as an entry point to services for people experiencing a mental illness which causes or may cause serious harm to themselves or others, meeting the legal threshold for compulsory intervention. Compulsory treatment under the Act provides an opportunity for a person experiencing a serious mental illness to begin to live well in the community and take self-ownership of their health care. This is promoted through a focus on regular collaborative consultation between compulsory patients and clinicians, and the statutory presumption in favour of minimally restrictive treatment in the community.

The Ministry of Health requires that clinicians regularly engage in recovery planning with every compulsory patient. The mandatory requirements of the Act augment recovery practice in relation to compulsory patients. These requirements also reflect good practice in relation to any consumer of mental health services.

Clinicians are required to regularly discuss treatment options with compulsory patients (see 11.4). A responsible clinician should regularly make efforts to gain a patient's consent to treatment after thoroughly discussing various treatment options with the patient (see 10.2.1). Compulsory treatment reliant upon a second opinion should be a last resort (see 10.2.2). A second opinion will only persist for a reasonable period of time while a compulsory patient's mental state and treatment remains consistent with the scope of the opinion, and in any case for no longer than one year.

The Ministry also requires clinicians to undertake relapse prevention planning with long-term consumers of mental health services. Relapse prevention plans help consumers to better manage their own condition and to produce positive mental health and wellbeing outcomes.

10.2 Consensual and non-consensual treatment

Despite the use of compulsion, clinicians must make efforts to obtain a patient's consent to treatment whenever possible. In all cases except emergency treatment, a clinician must attempt to obtain a patient's written consent to treatment (section 59(2)(a)) which may be withdrawn at any time (section 63).

A compulsory patient is 'required to accept such treatment for mental disorder as the responsible clinician shall direct' during the first month that the compulsory treatment order is current (section 59(1)).⁶² After the first month of an order, if a patient does not consent to treatment compulsory treatment can still be given if a psychiatrist (not being the responsible clinician) appointed by the Mental Health Review Tribunal (MHRT) considers that the treatment is in the patient's interests (section 59(2)(b)).⁶³

Clinicians should always make sufficient records of section 59 procedures.

10.2.1 Consent⁶⁴

'Consent' as used in section 59(2)(a) is not the same concept as 'informed consent' that is understood by clinicians generally. Informed consent should be obtained in the absence of coercion, whereas consent to compulsory treatment necessarily requires some degree of coercion to have already been used. In this case, the patient whose consent is sought is already subject to a compulsory treatment order, and the refusal of consent will not normally bring a compulsory treatment order to an end. 'Consent' in this context therefore refers to both informed consent and the lesser 'assent', which may be influenced by an element of coercion.

Clinicians will experience significant difficulty in determining the extent to which a person's consent is influenced by coercion. In order to mitigate this, clinicians should offer all patients the choice of receiving a second opinion under section 59(2)(b). Clinicians should also remind patients of their right to seek independent psychiatric advice under section 69 with a psychiatrist of their choice.

Consent should only be sought when the patient has capacity for that decision (right 7(2), Code of Rights). A patient will not have capacity to consent if they are unable to:

- understand the information relevant to the decision (see 11.4)
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate their decision (by any means).

⁶² Note that an extension to a compulsory treatment order will not restart the requirement for a patient to accept treatment within the first month of an order under section 59(1) (see 6.11).

⁶³ Except in the case of electroconvulsive treatment and brain surgery.

⁶⁴ For further analysis see Skipworth J. 2011. *Capacity to consent to treatment in forensic mental health care*. PhD thesis: University of Otago.

If a patient lacks capacity to consent to treatment for mental disorder, the approval of a psychiatrist appointed by the MHRT must be obtained under section 59(2)(b) of the Act, and family or whānau should be consulted under section 7A(2). A second opinion must also be obtained when a patient with capacity refuses consent, and when a patient indicates that they want a second opinion.

10.2.2 Second opinions

An approved psychiatrist providing a second opinion under section 59(2)(b) must certify that the proposed treatment is in the 'interests' of the patient. 'Interests' does not simply mean one of many accepted treatments for the condition which causes no harm. A psychiatrist providing a second opinion under section 59 is required to do more than merely assess whether, for example, schizophrenia is normally treated with an antipsychotic; the test of the patient's interests is influenced by other legal requirements.

A psychiatrist providing a second opinion should:

- consider the patient's history, including the course of the illness and prior pharmaceutical regimes
- assess the relative risks and benefits of the range of potential treatment approaches
- consider the patient's views as far as they can be ascertained, by engaging with the patient where reasonably possible
- consider whether the treatment is the least restrictive alternative and proportionate to the assessed risks under the New Zealand Bill of Rights Act 1990 (NZBORA) and the Code of Rights
- consider whether the treatment is of maximal benefit to the patient and appropriate to the patient's condition (section 66)
- consider whether the treatment is necessary to achieve the purpose of compulsory intervention.

The second opinion psychiatrist may endorse the current treatment if that treatment appears to be appropriate and/or efficacious. As opinions on best practice with regards to a certain patient's condition are likely to vary between clinicians, it will be sufficient for second opinion psychiatrists to endorse any good practice treatment and then, if appropriate, suggest alternatives which must then be considered by the responsible clinician.

If a second opinion psychiatrist does not agree that the proposed treatment represents best practice in light of all the circumstances, the responsible clinician should ask the DAMHS to help resolve the disagreement. There are several steps a DAMHS could take in this situation:

- mediate a discussion between the responsible clinician and the second opinion psychiatrist to try and develop a best practice solution both can agree on
- direct that another approved psychiatrist provide a further second opinion
- if the DAMHS is an approved psychiatrist, provide a second opinion.

It will not be appropriate for the responsible clinician to select an approved psychiatrist based on the likelihood that their second opinion will agree with the proposed treatment.

10.3 Non-consensual emergency treatment

The law permits medical treatment to be administered in an emergency to any person who is unable to consent to such treatment. This exception is recognised by Right 7(1) of the Code of Rights. It applies to patients subject to a compulsory treatment order as it does to any other patient. Furthermore, section 62 of the Act effectively preserves the legal right to administer any treatment that is 'immediately necessary to save the patient's life, to prevent serious damage to the health of the patient, or to prevent the patient from causing serious injury to himself or herself or others'.

10.4 Electroconvulsive treatment

The special provisions relating to electroconvulsive treatment (ECT) are contained in section 60 of the Act. The Act provides two procedures by which ECT may be administered:

- the patient consents in writing to the treatment (section 60(a))
- a second opinion psychiatrist agrees that the treatment is in the patient's interests (section 60(b)).

Further information for consumers and their families is contained in the Ministry of Health publication *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know* (Ministry of Health June 2009).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) publication *Clinical Memorandum #12: Electroconvulsive Therapy*⁶⁵ should be taken into account whenever ECT is considered.

10.4.1 Electroconvulsive treatment with consent

The primary procedure contemplated by the Act is ECT with patient consent (section 60(a)). A responsible clinician should always attempt to gain a patient's agreement to ECT by fully explaining the expected benefits and side-effects in accordance with section 67 (see 11.4 below).

⁶⁵ RANZCP. 2007. *Clinical Memorandum #12: Electroconvulsive therapy*. URL: www.ranzcp.org/Policy-and-advocacy/Therapeutics-and-interventions.aspx (accessed 12 October 2012).

In order for any consent to be valid, the consenting patient must have the capacity to consent to ECT. The principles and practical guidance surrounding the seeking of informed consent are recognised and described in the RANZCP Code of Ethics (see Principle 5). It should not be assumed that a patient who passively acquiesces is competent to consent. It is also important to recognise that capacity to provide consent may fluctuate, so that an incompetent patient may regain capacity during a course of treatment. A return of capacity to consent to ECT, or a withdrawal of consent to ECT at any stage, should lead to a re-evaluation of the legal basis of any further treatment.

Because a clinician cannot easily measure the impact of coercion on a patient's decision, the clinician should always offer the patient a non-prejudicial second opinion under section 60(b) (see 10.2.1 above).

It is essential to provide adequate information to a patient for whom ECT is proposed (see 11.4 below). Poor information will not allow the patient to make an informed decision, and may lead to judicial review.⁶⁶

Because mental illness can affect capacity, it is desirable for compulsory patients to express views about the acceptability of possible future treatment options, including ECT, at a time when they have capacity to consider those options. If patients who have recorded competently expressed views on ECT lose their capacity to consent, those views must be considered by responsible clinicians and by psychiatrists providing second opinions under section 60 of the Act. Section 5 of the Act requires that clinicians exercise powers conferred on them with proper respect for the person's cultural identity and personal beliefs. It is important to note that section 67 of the Act states that a patient is entitled to receive an explanation of the expected effects of any treatment, including the expected benefits and likely side effects.

10.4.2 Electroconvulsive treatment with second opinion

ECT can also be administered in circumstances where the patient is either not competent to consent, or refuses to consent, so long as the treatment is considered to be in the interests of the patient by a second psychiatrist, approved by the MHRT, who practises independently of the requesting clinical team (section 60(b)). Although this potentially allows a patient's competent refusal to be overridden by what is considered to be in the interests of the patient, good clinical practice will dictate that this only occurs in exceptional circumstances.⁶⁷

⁶⁶ *JE v Capital and Coast DHB* HC Wellington CIV-2009-485-1106, 19 June 2009.

⁶⁷ See Principle 5 of RANZCP. 2010. *Code of Ethics*. URL: www.ranzcp.org/Resources/Statements-Guidelines/Conduct-and-Ethics.aspx (accessed 12 October 2012).

The Ministry recommends that a second opinion should apply only to one course of ECT treatments. Clinicians should attempt to obtain consent for each new course of treatment. In the case of an acute treatment course, it is recommended that consent be reviewed and renewed after approximately 12 treatments. In the case of maintenance (continuation) ECT, it is recommended that patients renew their written consent at regular intervals, such as every six months or every 12 treatments.⁶⁸

⁶⁸ RANZCP. 2007. *Clinical Memorandum #12: Electroconvulsive therapy*. URL: www.ranzcp.org/Policy-and-advocacy/Therapeutics-and-interventions.aspx (accessed 12 October 2012).

11 Part 6: Rights of patients and proposed patients

Sections 64 to 75 of the Act set out the rights of patients subject to the Act. Proposed patients have the same rights as patients (see 11.12 below) except the right to receive and send letters and postal articles (sections 73 and 74). This is because the short duration spent as a proposed patient (usually a few hours) makes those rights unnecessary.

The rights in sections 64 to 75 of the Act supplement the rights affirmed in the NZBORA and the rights enjoyed by all health service consumers under the Code of Rights (this includes patients and proposed patients under the Act). The powers for providing compulsory assessment and treatment under the Act should be read consistently with the rights in the NZBORA and the Code of Rights as far as possible.

11.1 Section 64: General rights to information

In addition to receiving information about proposed treatment (see 11.4 below), at the time of becoming a patient (section 64(1)), patients must be given a written statement of their rights as a patient under the Act and must be kept informed of their changing status and review and appeal rights (section 64(2)). Note that section 23(1)(a) of the NZBORA states that 'everyone ... who is detained under any enactment ... shall be informed at the time of the ... detention of the reason for it'. This right to information extends to proposed patients.

A person may become 'detained' for the purposes of section 23(1) of the NZBORA before becoming a proposed patient if the situation is urgent and section 38 procedures are adopted.⁶⁹ If the person is urgently detained under section 38, the DAO should if possible inform the person of the reason for their detention, their right to consult a lawyer and the right to have the validity of their detention determined by a court. This may be done by providing a written statement of those rights. It is good practice for DHBs to include a detained person's rights under section 23(1) NZBORA in the statement of rights required to be supplied under section 64(1).

11.2 Section 65: Respect for cultural identity

Respect for cultural identity includes enabling a patient to communicate in their language of choice, wherever practicable, and respecting cultural concepts such as those related to the body or to the appropriateness of interactions with male or female staff (see chapters 3 and 4).

⁶⁹ *Sestan v DAMHS, Waitemata DHB* [2007] 1 NZLR 767.

11.3 Section 66: Right to treatment

Patients have a right to receive medical treatment and health care for their mental disorder and, if an inpatient, to be offered the same level of treatment and care that would be available to any other hospital patient, for health conditions not related to the mental disorder.

11.4 Section 67: Right to be informed about treatment

Before starting any treatment, patients are entitled to receive 'an explanation of the expected effects of any treatment ... including the expected benefits and the likely side-effects' (section 67). This right supplements the general right of all health service consumers to receive all the information about treatment options and risks that any reasonable person, in the same circumstances, would expect to receive (rights 6(1) and 6(2), Code of Rights).

The quantity and quality of the information given will depend on the nature of the situation. In an emergency situation when it is necessary to treat a patient without their consent, a very limited explanation of what is happening will be sufficient. At all other times that treatment is given, the information provided should be comprehensive. Because clinicians should always try to seek the consent of patients, it is important that clinicians attempt to give a patient enough information as would allow a reasonable person to make an informed decision. This information should include:

- details of the drug, dose and method of administration proposed (if a proposed treatment is pharmaceutical)
- the likely course of the treatment
- the intended effects of the treatment on the mental state of the patient
- the possible side effects of the treatment
- any other relevant information.

If the information provided is not sufficient, there may be grounds for judicial review.⁷⁰

Patients are entitled to effective communication in a form, language and manner that enables them to understand the information provided, and in an environment that enables open, honest and effective communication (right 5, Code of Rights). It is essential that the information about the treatment be comprehensive. Consideration should always be given to the patient's present mental state, and information should be repeated as appropriate if that state alters. Information communicated in written form should also be explained verbally. Under right 6(4) of the Code of Rights, 'every consumer has the right to receive, on request, a written summary of information provided'.

⁷⁰ *JE v Capital and Coast DHB* HC Wellington CIV-2009-485-1106 19 June 2009.

11.5 Section 68: Further rights in case of visual or audio recording

Section 68 entitles every patient to be informed if any visual or audio recording is to be used. This right should be observed in any case when it is intended to record the treatment of a patient.

Note that rule 4 of the Health Information Privacy Code provides that health information must not be collected by a health agency by unlawful means or by means that are unfair or which intrude to an unreasonable extent upon the personal affairs of the individual concerned. Visual or audio recording of a patient contrary to section 68 of the Act would likely also be contrary to rule 4 and may entitle the patient to complain under the Privacy Act.

11.6 Section 69: Right to independent psychiatric advice

The personnel who undertake the statutory assessment procedures are appointed by the DAMHS. If exercised, the right to independent psychiatric advice entails an additional process that will usually occur only in a non-urgent situation. 'Independent' means independent of the process of treatment of the patient. It does not mean that a psychiatrist who is employed by another service will necessarily be provided. However, the Act states that the patient is entitled to seek consultation with 'a psychiatrist of his or her own choice'. Thus, if the named psychiatrist of the patient's choice is from another service, the consultation should be facilitated by the staff responsible for the patient's care and treatment. Advice from psychiatrists not employed by the DHB in which the patient receives treatment may incur costs that will be borne by the patient.

11.7 Section 70: Right to legal advice

Services should ensure that satisfactory arrangements have been made with the local branch of the New Zealand Law Society to ensure that a patient or proposed patient can obtain the services of a lawyer if they do not already have a lawyer. This can be facilitated by obtaining from the Law Society a list of names of counsel suitably experienced and trained to give legal advice under section 70 of the Act.

If a patient or proposed patient asks to see a named lawyer, that person should be contacted. Note that 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.

11.8 Section 71: Right to company and seclusion

Section 71 provides that every patient is entitled to the company of others. In practice, this right is applied in inpatient units to ensure that patients are not isolated without cause. There is no enforceable right for treating clinicians to ensure that a patient enjoys company in the community, but in some situations it may be appropriate for clinicians to take steps to promote social and family contact.

In rare cases it may become necessary for a patient or a proposed patient to be secluded for their own safety or the safety of others. In such cases, section 71 of the Act should be observed and the procedures set out in the publication *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health February 2010) and the *Health And Disability Services (Restraint Minimisation and Safe Practice) Standards* (NZS 8134.2:2008) should be adhered to. Assessment of a proposed patient should be conducted as a matter of urgency in such circumstances. No more force than is necessary should be used to seclude a person.

11.9 Section 72: Right to receive visitors and make telephone calls

This section equally applies to proposed patients or patients. In some cases a proposed patient may wish to advise others of their compulsory assessment under the Act and to make personal arrangements. If it is safe to do so, the proposed patient should be given access to a telephone. Depending on the nature of the inpatient unit and potential risks, it may be appropriate to seize a person's personal cell phone (see 11.13.1 below).

11.10 Sections 73 and 74: Right to receive/send letters and postal articles

The rights to send and receive letters and postal articles are limited by sections 123 and 124 of the Act when a person is undergoing compulsory assessment or inpatient treatment in a hospital. Correspondence not in the interests of the patient to send or receive may be withheld by the responsible clinician, unless the correspondence is to or from an official or legal or medical professional as specified in section 123(3). If a person has notified a hospital that they do not wish to receive communications from a patient, such correspondence may be withheld. These sections do not apply to proposed patients because of the short duration of the assessment period.

The Act does not consider the monitoring of electronic communications such as emails and text messages. The Ministry of Health considers that there is no requirement for inpatient facilities to supply computers or cell phones for patient use, but such amenities may be appropriate in certain facilities. If patients have access to such devices, responsible clinicians have the same powers to examine and withhold correspondence as if the communications were letters, but may not withhold letters to or from the people specified in section 123(3).

Withheld correspondence must be laid before a district inspector under section 125.

11.11 Section 75: Complaint about a breach of rights

Section 75 of the Act gives district inspectors jurisdiction to investigate complaints of breaches of the rights of patients under sections 64 to 74 of the Act (and proposed patients under section 63A).

All consumers of health and disability services may make complaints to the Health and Disability Commissioner regarding breaches of rights affirmed in the Code of Rights. Each region has a Health and Disability Services consumer advocate available to assist consumers in making complaints regarding a breach of their rights (section 30 of the Health and Disability Commissioner Act 1994).

Parliament has appointed an Independent Police Conduct Authority (IPCA) to investigate allegations of misconduct or neglect of duty by Police. The IPCA has primary jurisdiction in that area.

For further information, refer to the *Guidelines for the Role and Function of District Inspectors* (Ministry of Health February 2012).

11.12 Rights of proposed patients

Section 2A of the Act provides a definition of 'proposed patient'. Section 63A describes the rights of proposed patients. A person becomes a proposed patient when an application is 'made' under section 8A of the Act. An application is 'made' when both the application under section 8A of the Act and the certificate under section 8B of the Act are completed and received by the DAMHS. The rights of proposed patients pursuant to section 63A do not apply during the medical practitioner's assessment of the person under section 8B, or during the applicant's contact with the person.

Proposed patient status ends when a medical practitioner either:

- records a finding under section 10(1)(b)(i) of the Act, in which case the person does not become a patient, or
- records a finding under section 10(1)(b)(ii) of the Act, in which case the person becomes a patient.

A person should normally be a proposed patient for only a matter of hours. It is important that a written statement of rights is given to the proposed patient in conjunction with a section 9 notice. A proposed patient may exercise any right under the Act, but only to the extent that the compulsory assessment process is not unreasonably affected. The arrangements for a proposed patient's assessment examination, and the conditions and venue of a patient's detention, should not be unreasonably affected by any section in part 6 of the Act.

11.13 Rights under the New Zealand Bill of Rights Act 1990

Many rights under the New Zealand Bill of Rights Act 1990 (NZBORA) are relevant to the compulsory assessment and treatment process. The Ministry recommends that all mental health service staff take the NZBORA into account when making decisions under the Act. These guidelines highlight several areas of potential concern below. The central principle of the NZBORA is captured in section 23(5), which requires a person detaining someone under the Act to treat them with *humanity* and with *respect for the inherent dignity of the person*.

11.13.1 Unreasonable search and seizure

Mental health services have a duty of care to provide safe and appropriate services of a reasonable standard⁷¹ and to protect vulnerable consumers in their care from injury,⁷² and to take all practicable steps to ensure the safety of their employees.⁷³ Normally a power to search a person and/or seize their property must be specified in statute. No such power is specified in the MH(CAT) Act, but the Ministry considers that such a power is necessarily implied for the effective and safe provision of compulsory mental health care.

Section 21 of the New Zealand Bill of Rights Act 1990 (the NZBORA) requires that a search and seizure policy is reasonable, and that each particular act of searching for or seizing property must also be reasonable. To comply with section 21, inpatient units should develop search and seizure policies that provide for reasonable searches that:

- are non-arbitrary (for example, indicated by a structured and rational assessment)
- are rationally connected to the risk a person is thought to pose to self or others
- are proportional to the risk a person is thought to pose to self or others and only infringe rights and freedoms to the extent necessary to address that risk
- do not unduly diminish a person's dignity or invade their reasonable expectation of privacy.

In most situations a search may only be undertaken based on these principles. In determining whether a search and seizure policy or a particular instance of search or seizure is reasonable, the clinician or staff member should consider the principles above in the context of the:

- nature of the facility or ward
- level of compulsion the person is subject to
- seriousness of the potential harm to the person and to others

⁷¹ See for example right 4 of the Code of Health and Disability Consumers' Rights; section 66 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

⁷² Section 151 of the Crimes Act 1961.

⁷³ Section 6 of the Health and Safety in Employment Act 1992; section 22(1)(k) of the New Zealand Public Health and Disability Act 2000.

- imminence of the potential harm
- likelihood of the potential harm
- factors particular to a person.

Rational processes for search and seizure should always include:

- searches and seizures being carried out by appropriately experienced and trained staff
- adequate record-keeping, including a list of the items removed and giving a copy of the list to the owner of the property
- retention of property for only as long as necessary to achieve the purpose for which it was removed
- review of instances of search and seizure by management
- appropriate storage or disposal of property.

Clinicians should endeavour to discuss search and seizure policies with a person shortly after their admission. Any search and seizure procedure should also include opportunities and encouragement for patients to voluntarily hand over dangerous items, and attempts to gain the person's consent to a search whenever possible. Compulsory patients have a right to receive visitors under section 72, but it may be reasonable to exclude visitors or make visitors subject to searches if clinicians have reason to believe that a friend or relative of the patient is bringing dangerous or disruptive items onto an inpatient unit.

In some situations a search will be explicitly permitted by statute. For example, a personal search may be reasonable in the following situations.

- A senior clinician has reason to believe that an inpatient is in possession of controlled drugs. The clinician may ask the person to voluntarily hand over any controlled drugs, and a search may be carried out under a policy developed in line with the principles described above. However, if an intrusive or internal search becomes necessary, the clinician should not perform the search but may refer the matter to a member of the Police under section 18 of the Misuse of Drugs Act 1975.
- A person has reason to believe that a person is in the possession of a weapon or dangerous substance that the person is going to use to attempt to commit suicide or to commit an offence that could cause immediate and serious injury to any person or property. In such cases, characterised by extreme urgency and serious consequences, a personal search may be justified under s 41 of the Crimes Act 1961.

11.13.2 Proper process for detention under the Act

Section 22 of the NZBORA provides that a person has the right not to be arbitrarily detained. This means that a DAO or a member of the Police exercising a power to take and detain a person should only act according to a fair and consistent process based on the risk that a person poses to self or others.

Section 23(1) of the NZBORA requires the person detaining someone under the Act to inform them of the reason for their detention, their right to consult and instruct a lawyer, and the right to have the validity of their detention challenged in a court. These rights should be contained in the statement of rights given to a patient or proposed patient under section 64(1) of the Act.

11.13.3 Right to refuse medical treatment

Section 11 of the NZBORA provides that everyone has the right to refuse to undergo medical treatment. The Act provides an exception to that right, based on the potential harm of not providing compulsory treatment. It is therefore important that compulsory treatment is delivered in a way that complies with statutory requirements, respects a person's rights, and protects or enhances their dignity or mana where possible.

12 Part 7: Reviews and judicial enquiries

The clinical and judicial review process differs depending on the nature of a patient's treatment order. The review process for different types of treatment orders are outlined in Figures 3 to 6 (pages 72–75).

12.1 Duty to conduct clinical review of patients

All compulsory patients must be formally reviewed by the responsible clinician under section 76, 77 or 78 of the Act, depending on the type of order the patient is subject to. The first clinical review must occur within the first three months of the court order allowing compulsory treatment.⁷⁴ Subsequent clinical reviews must occur within six months of the previous review. Note that the duty to review a patient's condition regularly does not end when a compulsory treatment order is of indefinite duration.

A clinical review carried out under section 76, 77 or 78 of the Act must be solely for the purposes of that section, and not for the purposes of any other section under the Act, for example the gaining of a second opinion to allow compulsory treatment under section 59(2). Conducting a review to fulfil multiple purposes may be prejudicial to the patient and a breach of the principle of natural justice. For example, a patient may be more likely to consent to treatment under section 59(2)(a) if a concurrent review under section 76 could result in their immediate release.

If a responsible clinician does not review a compulsory patient within the time period provided by section 76, 77 or 78 of the Act, a district inspector may apply to the Mental Health Review Tribunal for a review of the patient's condition to ensure that a timely review occurs.

⁷⁴ It is not necessary to perform a clinical review within the first three months of an extended compulsory treatment order (see 6.11).

12.2 Applications to the Mental Health Review Tribunal

After a certificate of clinical review has been completed, any person to whom the certificate was sent may apply to the Mental Health Review Tribunal (MHRT) for a review of the patient's condition. An application can be facilitated through a district inspector. In all cases, permitted applicants to the MHRT under section 76(7)(b) will include:

- the patient
- the patient's welfare guardian (if applicable)
- the patient's principal caregiver
- the patient's general practitioner
- a district inspector.

If a clinical review has been carried out on a special patient found not guilty on account of insanity, or unfit to stand trial, the Director of Mental Health may also apply to the MHRT (sections 77(3)(b)(ii), 77(4)(b)(ii)). If a clinical review recommends release from compulsory status for a restricted patient, the Director of Mental Health may also apply to the MHRT (section 78(5)(b)). The Attorney-General and Minister of Health may also refer cases to the MHRT in certain situations under sections 77 and 78.

The MHRT may also review a patient's condition on its own motion (section 79(2)). Regardless of whether a patient has received a certificate for clinical review, there is no limitation on them communicating with the Convenor of the MHRT and requesting a review. There is no obligation for the MHRT to act on such a request.

12.3 Mental Health Review Tribunal reviews of patients

Following a clinical review, a person who has received a copy of the certificate of review (see 12.2 above) may apply to the MHRT under section 79, 80 or 81 of the Act, depending on the type of order the patient is subject to. The MHRT's procedure is set out in Schedule 1 to the Act.

The MHRT's jurisdiction is limited to a consideration of whether a patient remains mentally disordered (see 1.1 above). The MHRT cannot make recommendations as to the appropriateness of a patient's treatment; such concerns should be addressed to a district inspector under section 75. A number of MHRT decisions are anonymised and provided to the New Zealand Legal Information Institute, a publicly accessible online database of legal resources.⁷⁵ These decisions may assist applicants to the MHRT.

⁷⁵ www.nzlii.org/nz/cases/NZMHRT/

12.4 Appeal against Mental Health Review Tribunal decision

Following an MHRT review of a patient under a compulsory treatment order, in which the MHRT finds that the patient remains mentally disordered, any of the following people may appeal that decision to the court:

- Director of Mental Health
- Director of Area Mental Health Services
- the patient
- the patient's welfare guardian (if applicable)
- the patient's principal caregiver
- the patient's general practitioner
- a district inspector.

An appeal proceeds as if it were an application for review under section 16 (see 5.7 above).

Figure 3: Clinical and judicial review of patients under compulsory treatment orders

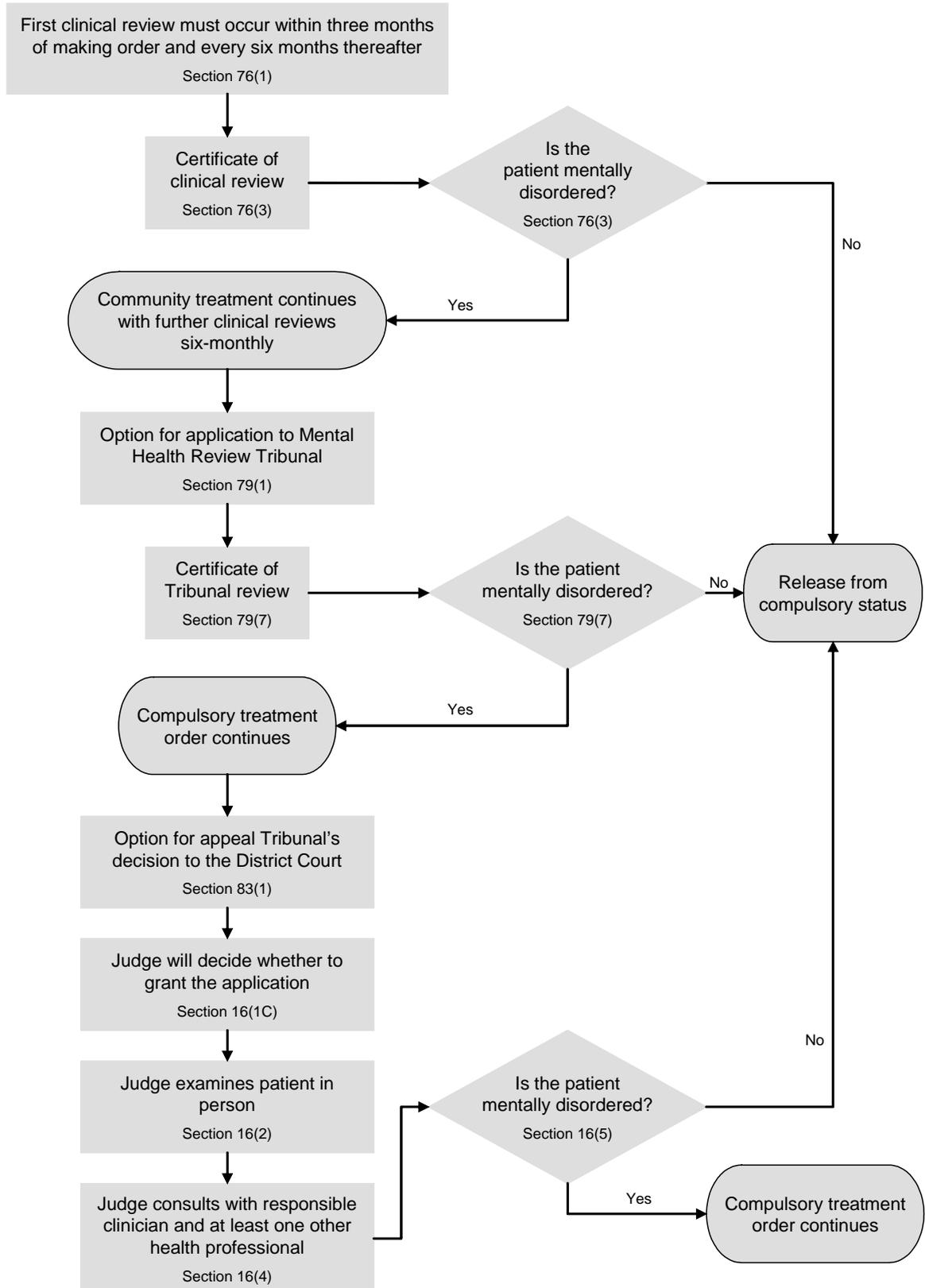


Figure 4: Clinical and judicial review of special patients acquitted by reason of insanity

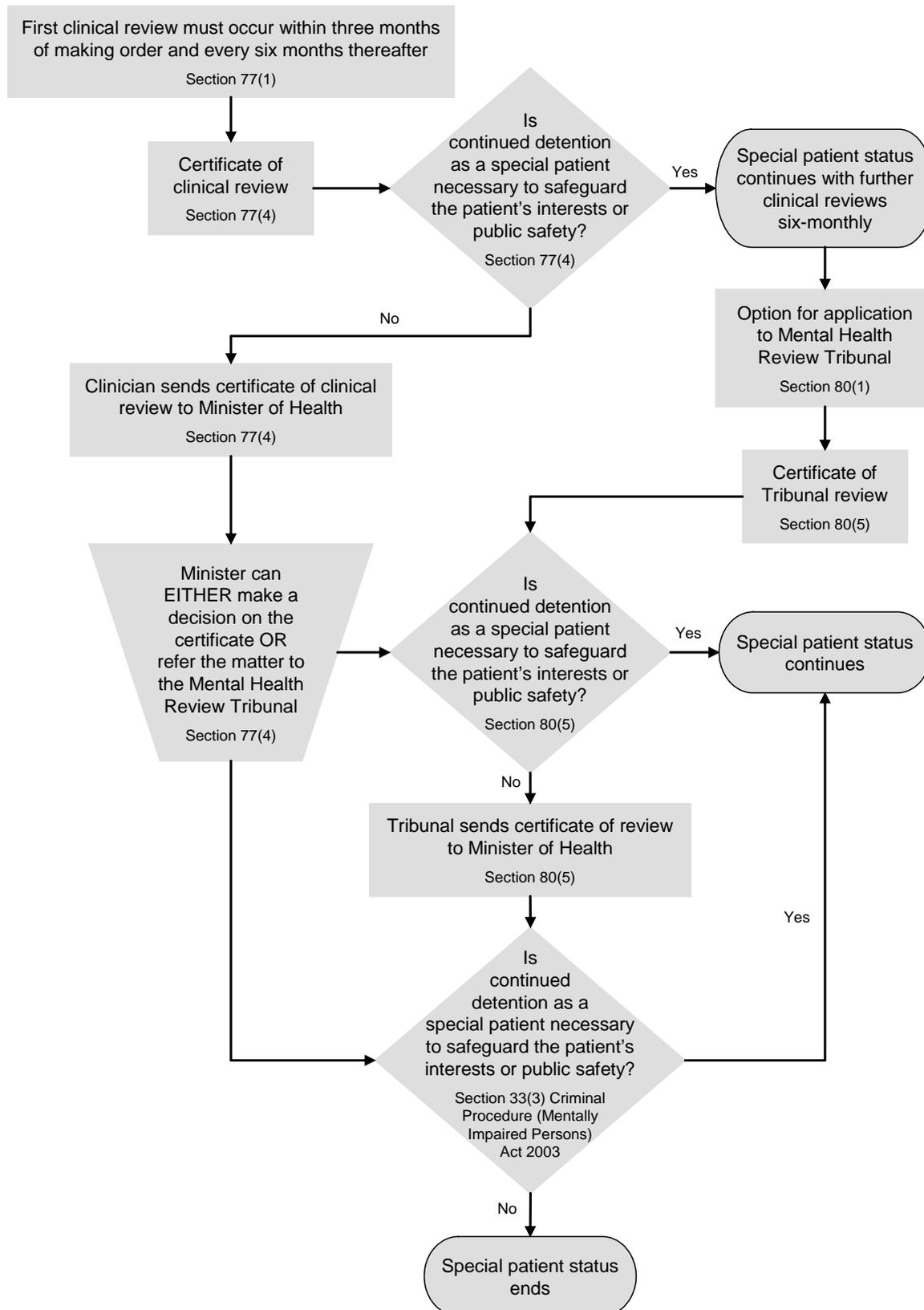


Figure 5: Clinical and judicial review of special patients found unfit to stand trial

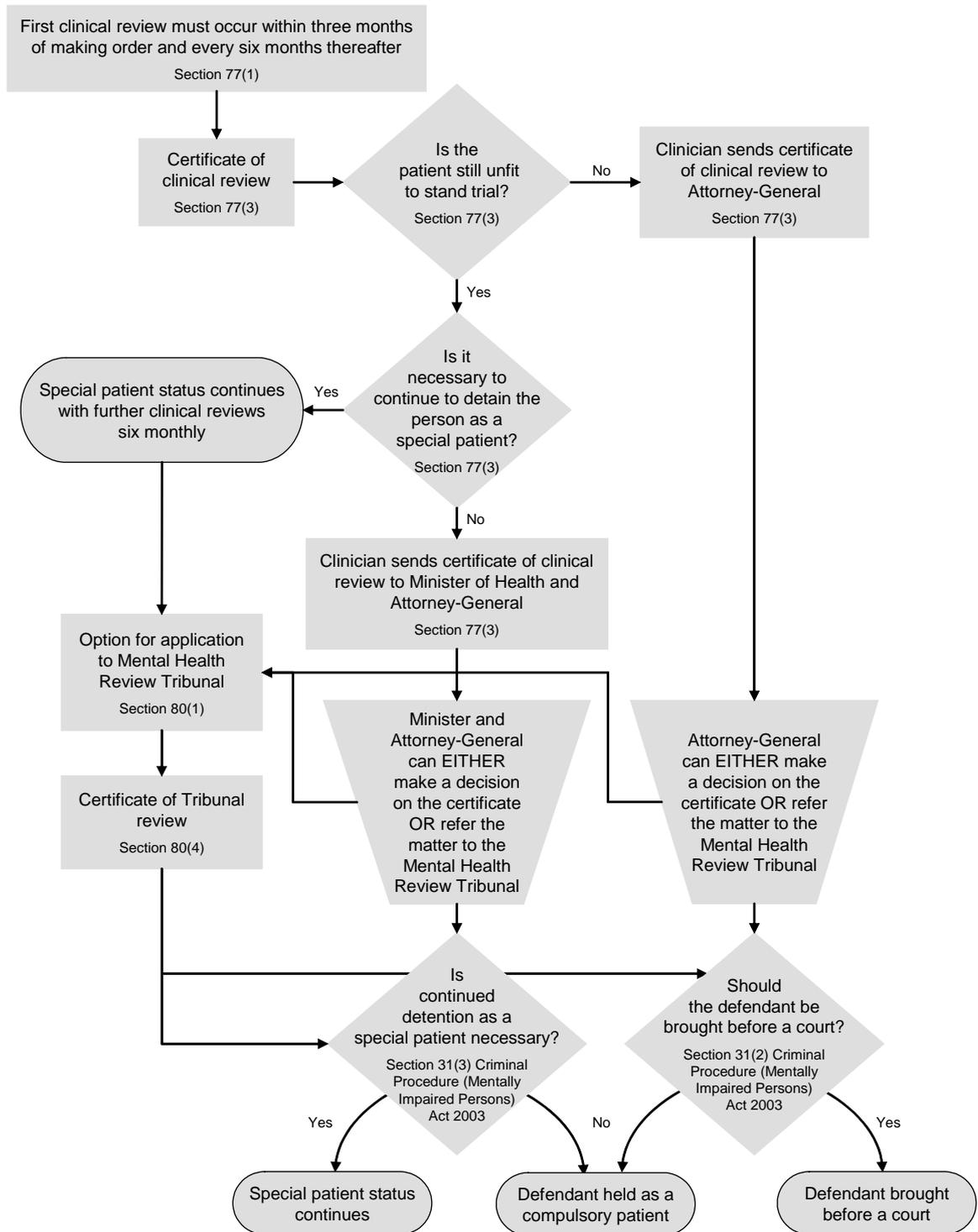
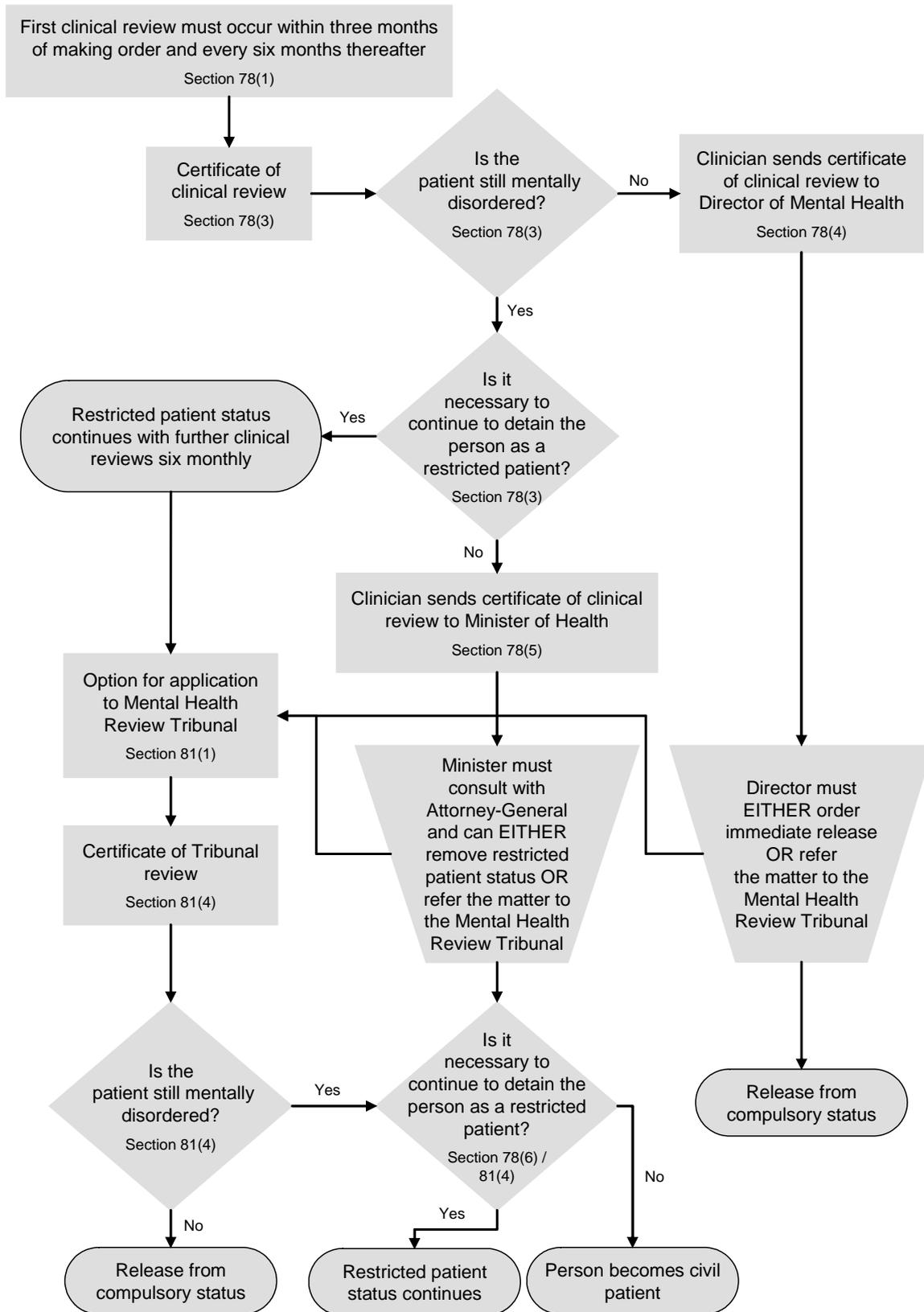


Figure 6: Clinical and judicial review of restricted patients



13 Part 8: Consent for young people and involvement of family/whānau

Part 8 of the Act contains specific provisions governing the treatment of patients and proposed patients who are under the age of 17 years and who are subject to the Act.

Section 86 of the Act states that ‘wherever practicable, an assessment examination of a person who is under the age of 17 years shall be conducted by a psychiatrist practising in the field of child psychiatry’.

For all practical purposes, a young person aged 16–19 years may be treated as if an adult for the purposes of giving consent. It is important to note that ‘in respect of a patient who has attained the age of 16 years, the consent of a parent or guardian to any assessment or treatment for mental disorder shall not be sufficient consent for the purposes of this Act’ (section 87).

A child/young person under the age of 16 years may give valid and effective consent if they have a sufficient understanding of the significance of the proposed treatment. This depends on the maturity of the individual child/young person, the effect of the relevant disorder at the time, and the seriousness of the matter for decision. If a child/young person under the age of 16 years is able to give consent, the consent of a parent/guardian is not necessary. If a child/young person under the age of 16 years is unable to give consent, the consent of a parent/guardian is necessary (except in an emergency or as authorised by sections 57 to 59 of the Act).

It is important to bear in mind the role of family/whānau in the care of children and young people who are mentally ill. Responsible clinicians should ensure that family/whānau are actively involved in the management of such patients. Note that the requirement to fully inform the patient about the treatment (as in 11.4 above) is not displaced by the fact that consent to treatment is sought from a parent or guardian.

14 Part 10: Enforcement powers and offences

14.1 Section 110: Powers of a medical practitioner when urgent examination is required

Under section 110 of the Act, a medical practitioner may request Police assistance to conduct a medical examination (section 8B). A medical practitioner acting under this section must make every reasonable effort to obtain the advice and assistance of a DAO.

14.2 Section 110A: Powers of a medical practitioner when urgent sedation is required

Section 110A of the Act allows a medical practitioner who issues a section 8B medical certificate to administer sedation to a proposed patient in an emergency.

The medical practitioner must have reasonable grounds for believing that the proposed patient presents a significant danger to self or to others and that it is in the proposed patient's interests to receive a sedative drug urgently. The medical practitioner may administer the drug, and if done it must be in accordance with relevant guidelines and standards of care and treatment issued by the Director-General of Health under section 130 of the Act (refer to *Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health April 2000)). The medical practitioner must make every reasonable effort to obtain the advice and assistance of a DAO and may call for Police assistance.

When a medical practitioner administers a sedative drug, they must record the circumstances in which the drug was administered and give a copy to the DAMHS as soon as practicable. The record should be made available to the consultant psychiatrist conducting the assessment examination for the purposes of section 9 of the Act.

14.3 Section 110B: Powers of a medical practitioner when urgent assessment is required

This section relates to an urgent assessment examination under section 9 of the Act. The medical practitioner (usually a psychiatrist) must conduct the examination as soon as possible. The medical practitioner must make every reasonable effort to seek the advice and assistance of a DAO, and may seek Police assistance.

14.4 Section 111: A registered nurse's power to detain

Section 111(2)(a) of the Act allows a nurse to detain, for the purpose of a medical examination, a person who has been admitted to hospital (or who has been brought to a hospital) who is believed to be mentally disordered. The power to detain under section 111 may only be exercised by a registered nurse.

Powers of detention are set out in section 113 of the Act. This detention cannot be for more than six hours from the time the nurse first calls for a medical practitioner to examine the person (section 111(3)). It should be noted that the power to detain is not limited to the premises of a psychiatric unit and should be exercised with discretion, according to good clinical practice.

Section 111 can be used when a voluntary inpatient seeks to leave a psychiatric unit at a time when no medical practitioner is available to assess them and a nurse suspects that the person is mentally disordered.

14.5 Section 113: Authority of the person in charge of a hospital or service to admit or detain

The person in charge of a hospital is authorised to take all reasonable steps to detain a patient or proposed patient for the purposes of compulsory assessment and treatment. The person in charge of a hospital can detain a patient or proposed patient for the purposes of:

- an assessment examination (section 9)
- assessment and treatment as an inpatient (sections 11 and 13)
- an inpatient compulsory treatment order.

The person in charge of the hospital or service may detain a patient or proposed patient in the hospital or service for the purposes of an assessment examination under section 9 of the Act. The period of detention must be no longer than six hours or the time it takes to conduct the assessment examination, whichever is less.

Section 113 of the Act also authorises the person in charge of a hospital to take all reasonable steps to admit and detain an individual subject to the Act. The interpretation of what is 'reasonable' will depend upon the balance of the risk to the patient and others and the autonomy of the individual patient.

The powers given to the 'person in charge of the hospital' will be exercised in practice by the staff of the hospital. The person in charge should ensure that the staff understand their powers and are properly trained to carry them out as safely as possible.

Detention may sometimes require the use of force. This should be only sufficient force as is necessary to ensure that a patient is detained safely. If needed, physical restraint or seclusion must be carried out in accordance with relevant standards and guidelines.⁷⁶ Consideration must be given to cultural differences when using force, for example avoidance of contact with the head of a Māori patient or proposed patient, if reasonably practicable.

14.6 Section 113A: Judge or registrar may issue warrant

This section authorises a District Court Judge or Registrar to issue a warrant authorising Police to apprehend any person who refuses to attend for an assessment examination as instructed by notices under section 9, 11, 13 or 18, or a hearing under section 19 of the Act, or a clinical review under section 76 of the Act. Police may then take that person to a place specified for such an examination to be carried out. The same power is given in respect of any patient refusing to attend a hospital in accordance with a compulsory treatment order or a place of treatment in accordance with a community treatment order.

The application must be made by the DAMHS or their representative. Section 113A of the Act does not confer a general power to seek a warrant for the apprehension of any person who is not cooperating with mental health services or hospital authorities.

14.7 Section 122B: Use of force

Section 122B of the Act authorises a person who is exercising a specified power in an emergency to use such force as is reasonably necessary to:

- take and retake a person
- detain a person
- enter premises.

The use of force should always be considered a last resort. Clinicians should be able to demonstrate that conflict resolution and de-escalation approaches were considered and attempted before using coercion. Any person using force may be criminally responsible if excessive force is used.⁷⁷

‘Force’ includes every touching of a person for the purposes of compelling or restricting movement or administering treatment. It will normally be appropriate for clinicians to use minimal force when exercising one of the powers above. ‘Minimal force’ means light or non-painful touching, for example to guide a person towards a building or room or help a person into or out of a vehicle.

⁷⁶ See *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health February 2010) and the *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (NZS 8134.2:2008).

⁷⁷ See section 62 of the Crimes Act 1961.

When more than minimal or inconsequential force is used while exercising a power under the Act, a log recording the circumstances must be completed by a DAO and forwarded to the DAMHS as soon as practicable. A log for this purpose should include:

- the date, time and place that force was used
- why force was required, including details of de-escalation attempts
- what type of force was applied and by whom
- any injury to patients or staff members involved
- any action or follow-up required as a result of force being used.

Services should refer to the Memorandum of Understanding between the New Zealand Police and the Ministry of Health, which provides guidance to Police and health professionals administering the provisions of the Act, as well as any local agreements made under the Memorandum of Understanding. Detailed guidance around the use of force by DAOs is provided in *Guidelines for the Role and Function of Duly Authorised Officers* (Ministry of Health 2012).

14.7.1 Use of force to administer compulsory treatment

Force as is reasonably necessary in the circumstances may be used for the purposes of compulsory treatment, provided that the processes in Part 5 of the Act relating to consent and second opinions have been followed (section 122B(3)). Force includes minimal touching as necessary to administer treatment (for example, the prick of a needle).

The use of force will not be permitted where the responsible clinician has failed to properly seek consent when treatment is established or changed, or failed to obtain a concurring second opinion where consent is not given. The administration of treatment without compliance with Part 5 could be considered an assault in law. As such the Ministry recommends that responsible clinicians make prudent, good faith efforts to comply with Part 5.

It is not necessary to record the use of minimal force to administer compulsory treatment in accordance with section 122B(3) and Part 5 of the Act.

14.7.2 Use of restraint

The ability to use force when exercising a power under the Act implies that in some cases restraint may reasonably be used. The use of restraint by mental health services is governed by the *Health And Disability Services (Restraint Minimisation and Safe Practice) Standards* (NZS 8134.2:2008).

14.8 Section 114: Neglect or ill-treatment of patients or proposed patients

It is an offence under the Act to intentionally neglect or ill-treat patients or proposed patients.

This section applies to:

- the person in charge of the hospital or service where a proposed patient attends for the assessment examination
- the person in charge of a hospital in which the patient is an inpatient
- a person employed in a hospital or service engaged in the assessment of a proposed patient or treatment of a patient
- the person in charge of a home, house or other place where a patient or proposed patient resides.

Such an offence is punishable on conviction by a prison sentence not exceeding two years.

Appendix 1: Other guidelines and documents published by the Ministry of Health

Many of these guidelines are available on the Ministry of Health website (www.health.govt.nz) as current publications or archived in the Ministry of Health Online Library Catalogue, or can be ordered in hard copy, unless otherwise specified.

- *Guidelines for the Role and Function of Duly Authorised Officers* (November 2012)
- *Guidelines for the Role and Function of Directors of Area Mental Health Services* (November 2012)
- *Guidelines for the Role and Function of District Inspectors* (February 2012) (online only)
- *Mental Health and Addiction Services for Older People and Dementia Services* (June 2011)
- *Te Ariari o te Oranga: the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems* (April 2010)
- *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (February 2010)
- *Electroconvulsive Therapy (ECT) in New Zealand: What you and your family and whānau need to know* (June 2009)
- *Victim Notification Guidelines for Directors of Area Mental Health Services and DHB Victim Notification Co-ordinators* (November 2007) (online only)
- *Competencies for the role and function of Responsible Clinicians under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (December 2001) (online only)
- *Involving Families: Guidance notes: Guidance for involving families and whānau of mental health consumers/tangata whai ora in care, assessment and treatment processes* (November 2000) (online only)
- *Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000) (online only)