

**GUIDELINES TO THE
MENTAL HEALTH
(COMPULSORY ASSESSMENT AND
TREATMENT)
ACT 1992**

1 April 2000

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It is important readers note that these guidelines are not intended as a substitute for informed legal opinion. Any concerns individuals may have should be discussed with appropriate legal advisors.

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FOREWORD

Section 130(a) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) states that the Director-General of Health may from time to time issue guidelines for the purposes of the Act. The following guidelines are intended to provide users of the Act with some guidance on issues of its interpretation and practical application.

The need for guidelines to the Act was identified by the Law Commission's report on *Community Safety: Mental Health and Criminal Justice Issues* (1994) and the *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services 1996* (the Mason Report, Ministry of Health 1996). Both reports stated that workable guidelines were required to address different understandings of the Act.

In June 1997 the Ministry of Health published the *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* to assist those involved in the administration of the Act to interpret some of the more important statutory phrases and principles. General feedback indicates that those guidelines have become an important resource document for the administration of the Act.

On 6 October 1999 Parliament passed the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999, which comes into force on 1 April 2000. Consequently, the 1997 guidelines have been revised to reflect the amendments made to the Act in 1999.

I wish to particularly acknowledge the contribution of Judge Geoff Ellis, Warren Brookbanks, Pauline Hinds, John Dawson, Karleen Edwards, Susan Noseworthy, Arana Pearson, Murray Patton, and David Chaplow to the production of these guidelines.

For information about specific aspects of the Act, the following Ministry of Health guidelines should also be consulted:

- *Guidelines for the Role and Function of Duly Authorised Officers under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000)
- *Guidelines for the Role and Function of Directors of Area Mental Health Services* (April 2000)
- *Guidelines for District Inspectors Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000)
- *Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000).

These guidelines are effective from 1 April 2000. On 1 July 2000, after a period of three months, the Ministry of Health will seek written submissions on errors, omissions, and points requiring clarification in these guidelines. The submission period will be for six weeks therefore submissions will close on 14 August 2000. Should you wish to make written submissions before 1 July please do so.

Submissions should be sent to:

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The guidelines will be revised accordingly and will be distributed by the end of December 2000.

Karen O Poutasi (Dr)
Director-General of Health

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INTRODUCTION

Guidelines must be seen in the context of the overall intent of the Act, which may be described as follows:

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

No piece of legislation can be framed in such a way that all circumstances that can possibly arise are precisely covered. In cases of ambiguity, it may take some time for an authoritative interpretation to be settled by the Courts. If there is uncertainty as to the 'correct' interpretation, any action taken should be consistent with the spirit and intent of the Act.

In practice, especially in urgent circumstances, situations may arise in which 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 (ie, in a manner more consistent with its purpose), then the purposively interpretation should be preferred.

A clinician, Duly Authorised Officer (DAO), police officer, or any other person should be able to justify his or her actions in terms of the powers conferred by the Act and should be able to demonstrate whether he or she is acting on a literal or purposive interpretation.

The amendments made to the Act in 1999 accord District Inspectors and members of the Review Tribunal civil immunity. This is to enable District Inspectors and members of the Review Tribunal to function in their role effectively, without being hampered by threats of litigation. However, any other person exercising any power under the Act does not have civil immunity. In other words, they are not immune from civil proceedings for negligent actions, even if undertaken in good faith. This is to ensure that any person purporting to exercise any power under the Act is properly accountable for his or her actions. It is not intended to prevent clinical staff or police officers from taking the actions necessary to ensure that a mentally disordered individual is given appropriate care and treatment promptly and safely.

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.

1. SECTION 2: DEFINITIONS

1.1 '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.

There are two circumstances in which a patient may be considered 'fit to be released from compulsory status':

- the patient is no longer 'mentally disordered'; *or*
- the patient continues to meet the criteria for 'mental disorder', but compulsion is no longer necessary where the patient agrees to continue with the necessary treatment on an informal basis and is not a danger to self or to the public, and this agreement is informed and genuine.

In making the decision that a patient is fit to be released, the responsible clinician (or Review Tribunal or Judge) should indicate in the clinical record which circumstance applies.

The description 'fit to be released from compulsory status' relates solely to the state of health of the patient, and not to the legality of the detention (see *BWA* [1995] NZFLR 321, Judge O'Donovan). It is not concerned with the issue of whether a patient needs to be treated in hospital (in contrast to sections 11(5)(a) and 84(3)(b)).

The test of fitness to be released is worded conjunctively, so that the patient must be both 'no longer mentally disordered' *and* 'fit to be released'. In practice this means that a patient who no longer meets the criteria for 'mental disorder' will be regarded as 'fit to be released' (ie, the 'and' is interpreted to mean 'or'). The rationale given by the Review Tribunals is that the criteria for entry to and exit from compulsory assessment and treatment should be the same (see, for example, *Re JM*, 16/4/96, Southern Review Tribunal (SRT) 16/96). Since the Act is concerned only with the compulsory assessment and treatment of people who are 'mentally disordered', it follows that a person who is no longer 'mentally disordered' is thereby 'fit to be released' (see *Re W*, 1/3/95, Northern Review Tribunal (NRT) 304/95).

It is important to note that the MH(CAT) Act does not authorise the detention of a person who is not mentally disordered simply for the purposes of preventative detention.

1.2 'Mental disorder'

The *Mason Report* (Ministry of Health 1996) noted that 'now that the interpretation of the legislation is better understood and "settling down", it would be unwise to make further sudden far-reaching changes' (p 47), and that 'the remedy [to any interpretative difficulties] is not to amend the definition' of mental disorder (p 45), but rather to provide clear guidelines.

1.2.1 General points

The definition of ‘mental disorder’ is based on phenomena rather than diagnosis.¹

Parliament has deliberately eschewed reference to particular major mental disorders as understood in the psychiatric community. Rather it has set the parameters for establishing the existence or otherwise of a mental disorder according to the presence or absence of observable symptomological indices.

(Re Review Tribunal (RT), 12/4/96, SRT 13/96)

The actual diagnosis remains relevant in relation to:

- the exclusions in section 4 of the Act
- defining the prognosis and likelihood of continued need for compulsory treatment, particularly in the case of intermittent disorders.

1.2.2 Intermittent disorders

The definition of ‘mental disorder’ specifically includes intermittent disorders. This serves to emphasise that most of the major mental disorders follow a fluctuating course. Frequently, remission of illness may be due to compliance with treatment. There is no requirement that the phenomena on which the diagnosis of mental disorder are 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 for a person who appears well (free from symptoms) in the following circumstances:

- 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 that results in an inability to maintain a consistent decision.

At these times, continuing compulsory treatment may provide for a more intensive overview and the possibility of early intervention should there be a relapse. It is good clinical practice to try to ensure relapse prevention, and the statutory reference to ‘intermittent nature’ encourages that possibility.

¹ ‘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 is 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 John Dawson, *Psychopathology and Civil Commitment Criteria*, Medical Law Review, 4, Spring 1996, pp 62-83).

1.2.3 Degree of disorder

There are two alternative definitions of the degree of disorder necessary to invoke the Act. Both are equally applicable and should be carefully considered. The order in which they are presented in section 2 of the Act is irrelevant. Criterion (b) should be considered carefully:

‘(b) Seriously diminishes the capacity of that person to take care of himself or herself’

People whose capacity is seriously diminished include those individuals whose judgement is impaired to the extent that they are unable to take care of themselves in a way that would be generally accepted as compromising their ability to maintain themselves. It is not enough that the individual simply chooses an alternative lifestyle. The degree of impaired care should be of sufficient magnitude to put the health or safety of the individual at significant risk.

For example:

- failure to comply with life-supporting medication (eg, insulin)
- self neglect, such as inattention to cooking and a consequent risk of fire
- a person in a manic state who overspends to such an extent that he or she finds himself or herself bankrupt when symptoms of mania are no longer present.

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

Although the meaning of ‘serious danger’ caused difficulties in early rulings under the Act, the situation has been now been clarified. When considering ‘a serious danger to health’, both physical and psychological health should be considered (see *Re RWD* [1995] NZFLR 28 Judge Doogue). The clinician should also consider whether the risk of deterioration of the illness process itself, as the result of lack of treatment, might constitute a serious danger to the health or safety of the person or of others. The following elements may be useful in determining if a ‘serious danger’ is posed:

- the nature and the magnitude of harm
- its imminence
- its frequency
- situational circumstances and conditions that affect the likelihood of the harm occurring
- balancing the alleged harm against the nature of the proposed intervention.

1.2.4 Examples of ‘serious danger’

The following are examples of cases in which the ‘serious danger’ test has been met.

- *Re D* [1995] NZFLR 28, Judge Doogue – ‘[T]he statute requires the Court to have regard not just to the possibility of physical harm, but also to the impact of the patient’s behaviour on the psychological and emotional wellbeing of himself and others’ (p 45). ‘Fear and feeling threatened can be as disabling to the victim as violence itself’. (p 46)

- *Re T* [1995] NZFLR 351, Judge Boshier – ‘[I]t is important to consider psychological harm to the patient or members of the public and the definition so permits. I prefer an approach that requires the psychological wellbeing of patients and members of the public to be enhanced and protected. Too restrictive an approach has the undesirable consequence of not only permitting people to become grossly unwell before intervention is possible, but also it wrongly exposes members of the public to the consequences of that unwellness.’ (p 355).
- *Re IC* [1996] NZFLR 562, SRT – Where there was evidence that a patient’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 Southern Review Tribunal 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’. (p 575).

1.2.5 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 8(3)(b) of the Act, the medical practitioner must ‘consider that there are *reasonable grounds for believing* that the proposed patient *may* be mentally disordered’
- under sections 10 and 12 of the Act, the medical practitioner must consider that there are ‘*reasonable grounds for believing* that the proposed patient *is* mentally disordered’.

However, under section 27(1) of the Act, the Court must ‘consider that the patient *is* mentally disordered’ in order to make a compulsory treatment order.

The test of ‘reasonable grounds for believing’ may be derived both from the medical practitioner’s examination of the patient and/or from information given by caregivers, family, and third parties. In determining ‘reasonable grounds’ it is important to note that fanciful or unsubstantiated grounds are not ‘reasonable grounds’ for believing a person is mentally disordered.

The significance of this difference is that whereas there is a reasonable certainty required before a compulsory treatment order can be imposed by the Court, a clinician can act to invoke compulsory assessment on much less certainty. There is thus the capacity to compulsorily detain and assess in cases where there is some doubt, but where the assessing clinician feels it is prudent to err on the side of caution.

1.2.6 Abnormal state of mind

‘Abnormal state of mind’ may refer to a state that is:

- 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 (see *R v T* [1993] DCR 600, Judge McElrea).

In many cases, both meanings will apply. There may be instances in which interpretation is an issue. Clinicians should be aware of the two possible meanings, and should be clear which meaning applies in the particular case.

Particular care should be taken to ensure that the state of mind is ‘abnormal’ in terms of the individual’s cultural norms.

1.2.7 Disorders of volition and cognition

The concepts of ‘delusions’, ‘disorder of mood’, and ‘disorder of perception’ are clinical concepts that are well defined and, in general, do not pose problems.

However, the concepts of ‘disorder of volition’ and ‘disorder of cognition’, are not well defined clinically, and are open to a wider range of interpretation, as explained below. The intent of the authors of the Act, in including the term ‘disorder of volition’, was primarily to ensure that the amotivational syndrome of schizophrenia was included in the definition. This term may, however, be applied to a variety of other conditions. The following definitions are intended to provide guidance.

‘Disorder of volition’

Volition can be defined as either the exercise of the will or power of willing, *or* the act of power or willing. In psychiatric textbooks, it is defined as the ‘state of energy and drive which directs our purpose or activity’ (sources: *Oxford Concise Dictionary* (8th ed in 1990), *Dorlands Illustrated Medical Dictionary* (28th ed in 1994), *Oxford Textbook of Psychiatry* (3rd ed in 1996)).

From a psychiatric perspective, a disorder of volition clearly covers:

- 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. There are rare states such as conversion disorders, sleep walking, and epileptic automatism that would 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, patients are aware of their actions and potential outcomes and have normal reality testing, but act according to an impulse or desire for a variety of reasons and a variable degree of pleasure or distress. 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 disorders of volition 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 disorders 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, diagnostic systems such as DSM-IV refer to all the behaviours it describes as ‘disorders’, although many are clearly not ‘mental disorders’ (as defined in the Act) that could ethically be subject to compulsory treatment. These factors result in confusion about where ‘disorder of volition’ should appropriately be used. Most psychiatrists would probably feel that there are times with obsessive compulsive states and eating disorders where compulsory treatment is appropriate. Certainly a diagnosis of borderline personality disorder does not preclude a person from coming within the ambit of the Act if he or she meets the definition of ‘mentally disordered’ (see *RT*, 12/4/96, SRT 13/96).

There is a presumption in the Act that an individual has the right to choose and the right to take responsibility for the outcomes of his or her choices. It is only in very particular circumstances that society takes away such power of choice. In general, conditions such as psychosexual disorders and anti-social personality disorder do not fall within such circumstances, unless complicated by another mental abnormality such as a disorder of mood, perception, cognition, or disorder of delusion.

‘Disorder of cognition’

Cognition can be defined as ‘the action or faculty of knowing, perceiving, conceiving, as opposed to emotion or volition’. An alternative definition is the ‘operation of the mind by which we become aware of objects of thought or perception including understanding and reasoning’. Cognition is loosely defined in psychiatric literature. It refers to obtaining, organising and utilising sensory and perceptual information from the environment, past experience, and such mental activities as plans and strategies. Cognition is not a term generally used in psychiatry. As well as referring to a process, cognition is at times used as a noun to mean ‘a thought’ (sources: *Oxford Concise Dictionary*, *Dorlands Illustrated Medical Dictionary*, *Oxford Textbook of Psychiatry*).

‘Disorder of cognition’ clearly covers:

- 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 eating disorders
- anxiety disorders with recurrent ruminations.

The status of some states where there is a recurrent thought that is dangerous (for example, paedophilia) is uncertain.

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. Intellectual disability has been held to be included in the definition of mental disorder for the purpose of the 'under disability' test in section 108 of the Criminal Justice Act 1985.

There are fewer difficulties in defining a 'disorder of cognition' than a 'disorder of volition'. The potential difficulties with the use of the term 'disorder of cognition' are primarily the confusion between cognition as a process and a cognition as a thought. The latter use, if adopted as a means of including people with deviant but non-delusional thoughts, is an inappropriate extension of the term. If cognition is seen as the process of thinking, perceiving and recalling, then the use of this concept should not spread excessively beyond that which was originally conceived by the authors of the 1992 Act.

1.2.8 Head injury

There appears to be a widely held misapprehension that the Act does not apply to individuals presenting with disturbances of behaviour resulting from head injury, on the grounds that they are not 'mentally ill'. However, the Act can be used in this situation.

As mentioned the definition of mental disorder under the Act is quite 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 brain injury, 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.

It is important to differentiate clearly between the application of the law and what is considered to be clinically appropriate in any individual case.

A patient subject to the Act may be assessed and treated in any hospital, or in any other appropriate community setting. Use of the Act is not necessarily synonymous with admission to a psychiatric unit.

If a clinician considers that intervention by the mental health service is not possible or appropriate without the patient's admission to a psychiatric unit, such a judgement should be based on the best use of clinical resources and the needs of the individual, rather than on the criteria of the Act.

1.2.9 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.

The Review Tribunal has recently reiterated that the Act is not concerned with diagnostic labelling in relation to whether personality disorder is included within the definition of mental disorder as a 'disorder of volition'. Thus the fact that a current diagnosis suggests the presence of a borderline personality disorder of a severe type does not preclude a person from coming within the ambit of the Act (see *RT 12/4/96*, *SRT13/96*).

1.2.10 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 may be.
- The effects of intoxication may present as mental disorder, for example the effects of hallucinogenic drugs. The disturbance may be seen as a mental disorder irrespective of its causation and the Act may be invoked in the acute situation should this be necessary.

- Mental disorder may arise as the consequence of substance abuse, for example the cognitive impairment of a Korsakoff's psychosis or a drug induced psychosis. If there is a mental disorder, irrespective of its underlying causation, the Act may apply.
- Individuals who have a so-called '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 he or she also has 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.

1.3 'Person in charge'

The Act defines the person in charge of a hospital or a service to be the chief executive officer. It is relevant to note that section 99B of the Act enables the person in charge of a hospital or service to delegate his or her powers under the Act to another person who is suitably qualified. For example, powers may be delegated to members of a psychiatric crisis team (see section 99B for further information).

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 14(4)(b)(iv)) 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 (the Privacy Act) does not affect the clear statutory duty of notification in these circumstances (see *EW*, 24/1/96, DC Auckland, Judge McElrea), nor does the Health Information Privacy Code or the Code of Health and Disability Services Consumers' Rights (the Code of Rights).

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, his or her advice as to who the principal caregiver is should be accepted.

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

- *whether* the patient is competent to advise whom the principal caregiver is; *and*
- *who* the ‘principal caregiver’ is for the purposes of the Act

should be that of the Director of Area Mental Health Services (DAMHS), who will be advised by the responsible clinician or appropriate DAO involved. In cases of dispute, the DAMHS should consult with other knowledgeable parties, for example a keyworker. 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 in *Re H M, 4/4/99, FC Auckland, Judge Inglis*, it was held that more than one principal caregiver may be appointed.

1.5 ‘Proposed patient’

Section 2A of the Act provides a definition of ‘proposed patient’. 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.

Proposed patient status ends when:

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

It is important to note that a person should only be a proposed patient for a matter of hours.

2. SECTION 4: EXCLUSION CRITERIA²

The exclusion factors in section 4 of the Act 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 the mentally ill 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 above at 1.2.10. (see *GBW* [1995] NZFLR 428).

Section 4(e) of the Act excludes the application of the Act on the grounds of intellectual disability alone. The Intellectual Disability (Compulsory Care) Bill 1999 proposes limits that can be imposed on the freedoms of people who have an intellectual disability and who because of dangerous behaviour are in need of compulsory care, by requiring them to accept care programmes. The Bill also uses a framework for protecting the rights of individuals subject to compulsory care.

The Bill intends to cover children, young people, and adults who fit all of the following criteria:

- they are offenders or non-offenders
- their behaviour poses a serious risk of danger to themselves or to others
- they are mildly to profoundly disabled and cannot or do not voluntarily consent to care.

There are relatively few reported judgements addressing the exclusion criteria in section 4 of the Act. This is probably because of the narrow wording of section 4 of the Act. Section 4 of the Act does not prohibit assessment and treatment in relation to patients who have a mental disorder but might otherwise fit within one of the categories in section 4 of the Act. In *Re H* [Mental Health] (1993) 10 FRNZ 422, 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.

² 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 11–12.

3. SECTIONS 5 AND 6: RESPECT FOR CULTURAL AND PERSONAL RIGHTS

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. The amendments made to the Act in 1999 make it clear, by changing the word ‘patient’ to the word ‘person’, that section 5 of the Act 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 or an interpreter and appropriate cultural advisors, often at short notice.

3.1 Cultural identity

Some specific issues are discussed below.

‘proper respect for the patient’s cultural and ethnic identity...’ (section 5(a))

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 Rights. It should be incorporated into the assessment and management of individual patients by ensuring that cultural assessment is a key component of assessment (see *Guidelines for Cultural Assessment in Mental Health Services*, Ministry of Health 1995).

‘proper recognition of the importance and significance to the patient of the patient’s ties with his or her family, whānau, hapu, iwi, and family group ...’ (section 5(b))

This requires that family/whānau relationships be recognised as integral to the patient’s wellbeing. Family/whānau should be encouraged to provide information about the patient, in terms of that individual’s history and feedback on any changes noticed when the patient 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 patient and his or her family/whānau may change over time. A patient who refuses contact with family/whānau may change his or her mind and the wishes of family/whānau should be considered wherever 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 patient. For example: if such disclosure was one of the purposes for which the information was collected; if there is a serious and imminent threat of self-harm by the patient; or if the patient is being discharged into the care of family/whānau (see *The Mason Report*, Ministry of Health 1996, ch. 4). In fact, the patient’s family/whānau should be educated about aspects of the patient’s illness if

they are expected to be a part of that patient's support group. For example, they should be provided with information about the patient's medication needs and any kinds of behaviour they should be concerned about.

3.2 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 but not be limited to Māori and New Zealand Sign Language. 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 patient should be sought, particularly prior to any court or tribunal proceeding. It should not be assumed that a patient is happy to communicate in English simply because he or she is able to do so. Section 6(2) of the Act also recognises that patients 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 a competent interpreter. This requirement applies equally to interpreters for people who are profoundly deaf as well as for people from different ethnic groups. When deciding if it is reasonably practicable to provide a competent interpreter, factors to consider include:

- urgency (ie, the safety of the proposed patient or others)
- expenses
- other disadvantages. All disadvantages must be balanced with the potential benefits to the person (for example, the availability of a competent interpreter).

Section 6(2) of the Act also recognises New Zealand Sign Language as a language. It is important to note that the community of people who are profoundly deaf 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.³ Mental health services should be responsive to people, patients, and proposed patients who are profoundly 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 his or her deafness has specific relevance and meaning.

A registered New Zealand Sign Language interpreter is considered to be a competent interpreter for the profoundly 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.

³ *Moving Forward*. Ministry of Health 1997. pp 42–43.

4. SECTION 7A: REQUIREMENT TO CONSULT 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.

When making a decision about whether it is in the best interests of the patient or proposed patient, a medical practitioner or responsible clinician must first consult with the patient or proposed patient.

A clinician is required to apply any relevant guidelines and standards of care and treatment issued by the Director-General of Health (issued under section 130 of the Act) when deciding:

- when and how to consult family/whānau or the patient or proposed patient
- whether or not consultation with family/whānau is reasonably practicable
- whether or not consultation with family/whānau is in the best interests of the patient or proposed patient.

4.1 General Comments

It is unlikely that the requirement to consult will address all family/whānau concerns regarding the compulsory assessment and treatment of their family/whānau member. It is also possible that section 7A of the Act may unduly raise family/whānau members' expectations about their role in clinical decision-making. It may also unduly raise the hopes of family/whānau that they will be involved in daily decisions concerning the care of their family/whānau member. Nevertheless, the requirement to consult should ensure more informed decisions are made.

It is the Ministry of Health's expectation that the requirement to consult with family/whānau will:

- strengthen family/whānau involvement in the compulsory assessment and treatment process
- enhance the contribution the family/whānau can make to subsequent care
- go some way towards addressing family/whānau concerns about information sharing and education about treatment options.

A patient or proposed patient's consent to consult family/whānau should be obtained wherever possible. The requirement to consult does not mean that a patient or proposed patient completely forfeits his or her right to confidential care and treatment. The rights of proposed patients and patients and the protection of those rights continue to be paramount and one of the major philosophical tenets of the Act.

4.2 Family and whānau

People's definitions and understanding of family/whānau vary and are informed by different cultural backgrounds and practices. The perspective of the person who identifies membership of a family/whānau is a critical factor in that process. The following definition is only one definition of family/whānau and is by no means the only definition. However, to avoid confusion it is recommended that the following definition be used as a guide.

Family/whānau is a set of relationships that is defined as family/whānau by the patient or proposed patient. A family/whānau is not limited to relationships based on blood ties and may include:

- relatives of the patient or proposed patient (including a spouse or partner); *or*
- a mixture of relatives, friends, and others in a support network; *or*
- only non-relatives of the patient or proposed patient.⁴

In some circumstances, a proposed patient or patient's definition of family/whānau will be at variance with this definition. If the patient or proposed patient is competent to make this decision, his or her advice as to what family/whānau is should be accepted because the patient or proposed patient is the 'expert' about most situations. In cases of doubt or dispute, the responsibility for the decision about:

- whether the patient or proposed patient is sufficiently competent to advise staff who the family/whānau is; *and*
- who the family/whānau is for the purposes of the section 7A of the Act

should be the responsibility of the DAMHS. The DAMHS will make this decision based on the advice of the responsible clinician, medical practitioner, or keyworker. If the patient or proposed patient identifies as Māori, the DAMHS should seek advice from Māori health workers and cultural support staff. In urgent circumstances, the clinician completing sections 10 and 11 of the Act would be responsible for this decision for the purposes of the Act.

In cases of dispute, the DAMHS should consult other knowledgeable parties, for example the patient or proposed patient's usual general practitioner, keyworker, Māori health worker, kaumātua, cultural support staff, Maori consumer advisory groups, Māori advisory committee, and other Māori providers of services to the patient or proposed patient, or a District Inspector.

4.3 Consultation

4.3.1 *How to consult*

In practical terms, consultation means *objectively* talking with affected parties and listening to what they have to say. It does not simply mean sharing information.

⁴ Royal Australian and New Zealand College of Psychiatrists. *Draft Guidelines for Involving Families of Mental Health Consumers in Care, Assessment, and Treatment processes* in press.

Consultation does not require agreement, nor does it necessarily involve negotiations towards an agreement, although this might occur – particularly as the tendency in consultation has been at least to seek consensus.⁵

Meaningful consultation consists of the following steps.

- Consulting in the formative stages of a process by giving adequate notice of a proposed decision or action (that is not yet finally decided upon) to affected and/or interested parties.
- Providing a reasonable amount of time for affected and/or interested parties to respond (this will depend on the urgency of the issue).
- The party required to consult can have a working plan in mind and inform interested/affected parties of this plan, but must keep an open mind and be ready to change or start afresh should this be required. It is important to note that consultation does not mean that clinical safety should be compromised.
- Providing affected and/or interested parties with a reasonable opportunity to formulate and state their views in a safe and open environment.
- Giving proper consideration to the representations of the affected and/or interested parties before deciding what will be done.
- Providing feedback to affected and/or interested parties on the outcomes of the consultation.

4.3.2 When to consult

Consultation with families/whānau is not a one-off event but an ongoing process. It is recommended that a medical practitioner or responsible clinician should consult when:

- significant treatment decisions are being made
- at each juncture of the compulsory assessment and treatment process, that is sections 9, 10, 14, 29, and 30 of the Act; reviews under section 76 of the Act; or when the practitioner or clinician is considering discharging the patient from the Act.

This may require the disclosure of a proposed patient or patient's personal and health information to families/whānau.

The disclosure of information for the purposes of consultation under section 7A of the Act is not a breach of the Privacy Act or the Health Information Privacy Code.⁶

⁵ *Wellington Airport v Air New Zealand* [1993] 1 NZLR 671.

⁶ See section 7 and section 53 of the Privacy Act 1993.

4.3.3 Consulting with a patient or proposed patient

A medical practitioner or responsible clinician must firstly consult with the patient or proposed patient to ascertain his or her views when making a decision to consult with family/whānau. The practitioner or clinician must also provide the patient or proposed patient with an opportunity to respond.

A patient or proposed patient can refuse to give permission for a medical practitioner or responsible clinician to consult with family/whānau. In this situation it is up to the practitioner or clinician to then decide whether consulting with family/whānau would be in the ‘best interests’ of the patient or proposed patient.

If the circumstances are urgent, a medical practitioner or responsible clinician should still talk with the patient or proposed patient and seek his or her views, but given the urgency the clinician may decide that it is either not in the best interests of the patient or proposed patient or reasonably practicable to consult family/whānau at that particular time. However, this should not necessarily preclude the clinician from communication with the family/whānau after a particular decision has been made, that is at the earliest possible opportunity, and before further subsequent action is taken.

4.3.4 Consulting with family or whānau

Medical practitioners or responsible clinicians who consult with family/whānau must use discretion to decide how much information to give to family/whānau. A practitioner or clinician must consider how much information a family/whānau needs to make informed and useful responses to the practitioner’s or clinician’s proposed course of assessment or treatment. The practitioner or clinician may have a working plan in mind but must keep his or her mind open and be ready to change or start afresh if this is required.

Consultation with the family/whānau of patients or proposed patients who identify as Māori should involve relevant Māori health workers, kaumātua, cultural support staff, tangata whai ora advocacy services,⁷ Māori advisory committees, or other Māori providers of services to patients or proposed patients who identify as Māori.

4.3.5 Best interests

‘Best interests’ is a concept that is used elsewhere in the Act (sections 19 and clause 2 of the First Schedule). The importance of the ‘best interests’ concept is that the interests of the individual come ahead of anybody else’s interests. In some cases, there may be a clash of interests between an individual and his or her family/whānau. The ‘best interests’ assessment means that those charged with applying it (the medical practitioner or responsible clinician) must resolve any such clash in favour of the individual about or for whom they are making a decision. In some situations in which individuals’ wishes are considered to be contrary to

⁷ Tangata whai ora means the one who is seeking wellness.

their own ‘best interests’, this may result in the practitioner or clinician charged with applying the best interests concept acting contrary to the wishes of the individual.⁸

In relation to section 7A(3)(a) of the Act, a medical practitioner or responsible clinician must have reasonable grounds for deciding that consultation with the family/whānau of a patient or proposed patient is not in his or her best interests. The need to make such a decision is only likely to occur when a situation arises in which the patient or proposed patient does not wish the practitioner or clinician to consult with the family/whānau yet the family/whānau wishes to be involved in the proposed patient or patient’s care and treatment.

To help determine the best interests of a patient or proposed patient, a medical practitioner or responsible clinician needs to consider all relevant clinical or personal information. Relevant information may include:

- the reasons the patient or proposed patient wants his or her family/whānau excluded from his or her care
- the wellness or competence of the patient or proposed patient to make such a decision
- the clinical and family/whānau history of the patient or proposed patient
- any previous contact the patient or proposed patient has had with other mental health service providers
- the likelihood of the family having information not available from other sources
- any advance directives the patient or proposed patient may have made.

If a patient or proposed patient identifies as Māori, the medical practitioner or responsible clinician needs to consult with Māori health workers, Māori providers, and cultural support staff involved in the patient or proposed patient’s care.

4.3.6 ‘Reasonable grounds’ and ‘reasonably practicable’⁹

When considering whether consultation is ‘reasonably practicable’ the medical practitioner or responsible clinician needs to consider whether it is objectively feasible. Relevant factors to consider may be:

- urgency, (ie, the safety of the patient or proposed patient or others). For example, if the patient or proposed patient is acutely unwell and the clinician needs to act quickly.
- the time taken to contact family/whānau members as well as the time required for family/whānau members to formulate their views
- expenses (for example, [if a patient is in Auckland and their family/whānau lives in Invercargill](#) it may be more feasible to consult using the telephone or video-conferencing rather than meeting face to face)
- any other disadvantage.

⁸ 1993. *Family Law in New Zealand*. 6th edition. Wellington: Butterworths, pp 915–916

⁹ The term ‘reasonable’ brings a measure of objective consideration to a decision, that is whether with knowledge of the same facts another responsible clinician would make the same decision.

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

If the medical practitioner or responsible clinician decides that consulting with family/whānau is not in the best interests of the patient or proposed patient, the following points should be taken into account:

- the clinician can still seek information from the family/whānau
- the family/whānau can continue to provide information to the clinician
- the family/whānau may be given information that was collected for the purposes of disclosure to the family/whānau where the family/whānau is providing ongoing care (eg, information about medication prior to discharge)
- 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.

4.4 Māori

Māori have a distinct need for family/whānau involvement, as Māori generally see themselves more as members of their family/whānau than as individuals. The emphasis that 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. Any decisions concerning Māori individual interests versus family/whānau interests should not be made solely by a medical practitioner or responsible clinician. Rather, there must be involvement by Māori health workers, kaumātua, cultural support staff, tangata whai ora advocacy services, Māori advisory committees, and other Māori providers of services to tangata whai ora.

In order to implement section 7A of the Act appropriately and to ensure that mental health staff work effectively with family/whānau, staff may need:

- specific training resources
- appropriate cultural expertise
- to be supported by organisational development.

Māori have diverse realities and every family/whānau needs recognition and to retain cultural safety as it participates in care, assessment, and treatment processes.

To lessen the risk of inappropriate service delivery and to ensure that family/whānau remain culturally safe, mental health services may need to put a number of fundamental mechanisms in place. These should include:

- ensuring the involvement of kaumātua
- seeking guidance from other appropriate Māori support staff such as Māori health workers, Māori advisory group members, or tangata whai ora advocates

- seeking advice relating to tikanga Māori
- providing cultural safety training to staff
- ensuring the flexibility and responsiveness of staff.

In order 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.

The above comments apply equally to a proposed patient or patient who identifies as a Pacific person.

5. SECTION 8: THE ROLE OF POLICE AND DULY AUTHORISED OFFICERS (DAOs)

A medical certificate pursuant to section 8B of the Act must be obtained before an application for assessment is made (ie, is complete) under section 8A of the Act. Once an application is made, a DAO can request police assistance under section 41 of the Act to take a proposed patient to a nominated place for the purposes of an examination under section 9 of the Act.

Under urgent circumstances (section 38(4)(d)(i)) if there are reasonable grounds for believing the person may be mentally disordered, a DAO can request police assistance to take a person to a medical practitioner for the purposes of an examination under section 8B of the Act.

Services should refer to the revised Memorandum of Understanding between the New Zealand Police and the Ministry of Health (see pages 61–64), which provides guidance to members of the police and health professionals administering the provisions of the Act.

6. SECTION 9(1): ARRANGING 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’. Section 9(2) of the Act provides details about these arrangements. The DAMHS or DAO does not have to perform these functions personally but must ensure that necessary arrangements are made that are appropriate in the circumstances, including the urgency of the situation.

For example, if a medical practitioner is acting under section 110 of the Act (powers of a medical practitioner where urgent assessment is required), a phone call to the DAO or DAMHS is sufficient to decide by whom and where the assessment will occur. The DAO can ask the medical practitioner to give the notice to the proposed patient and explain what is to occur and the their rights.

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 (eg, 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 (Health Information Privacy Code 1994, Privacy Act 1993, and Health Act 1956; 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 patient).

7. SECTION 9(3)(B): ASSESSMENT EXAMINATION TO BE CONDUCTED BY A MEDICAL PRACTITIONER

The intent of the Act is to ensure that a psychiatrist or a medical practitioner with expertise in the assessment of mental disorder as approved by the DAMHS conducts the assessment examination. The decision to detain an individual is significant. The decision to detain and assess should be made by a practitioner with sufficient experience and expertise to ensure that it is competently made.

As with any other clinical service, a balance must be reached between the expertise available and the demands of the situation. As a minimum requirement, the 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.

The number of psychiatrists available to the service must be considered. 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.

8. SECTION 10(3): REASSESSMENT FOLLOWING RELEASE FROM COMPULSORY ASSESSMENT

This section of the Act notes that a further application under section 8 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.

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).

9. SECTIONS 11 AND 13: FURTHER ASSESSMENT FOR 5/14 DAYS

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. 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.

There has been considerable confusion as to how these periods are to be calculated. Both sections 11 and 13 of the Act refer to the 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’. In *Re DI* [1996] NZFLR 713, Judge Ellis confirmed that the five and 14 day periods should be computed *exclusive* of the day on which the notice is given to the patient.¹⁰

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.

9.1 Leave during the assessment and treatment process

Amendments to sections 11 and 13 of the Act enable a responsible clinician to allow a patient subject to compulsory inpatient assessment a short period of controlled leave (eg, ‘trial leave’) in the community, or to allow leave on compassionate grounds (eg, to attend a tangi). If the leave is for eight hours or less between 8 am and 10 pm, the Act requires it to be recorded

¹⁰ Section 25(b) of the Acts Interpretation Act 1924 states, ‘If in any Act any period of time dating from a given day, act, or event is prescribed or allowed for any purpose, the time shall, unless a contrary intention appears, be reckoned as exclusive of that day or of the day of that act or event’.

(along with the terms and conditions of leave) in the patient's clinical records (section 11(5)(a)). The patient's contact details while on leave should also be recorded.

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 (section 11(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.

10. SECTION 14: CERTIFICATE OF FINAL ASSESSMENT: PROVISION OF REPORTS TO THE COURT

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 status (see *LB* [1994] NZFLR 60) 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. It has been suggested that a pre-hearing conference between the patient, the clinician, and counsel will improve communication, save time, and assist in identifying key issues.

A report from the responsible clinician and other health professionals should 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, or the Alcoholism and Drug Addiction Act 1966
- 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.¹¹

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.

11. 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 treatment 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 from section 11 of the Act onward.

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)).

12. SECTION 29: COMMUNITY TREATMENT ORDER

12.1 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 a psychiatrist (not being the responsible clinician) appointed by the Review Tribunal considers that the treatment is in the patient’s best interests (sections 59(1) and (2)(b)). In all other cases, the patient’s informed and written consent to treatment must be obtained (section 59(2)(a)).

¹¹ 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

- 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 DAO may take ‘all reasonable steps’ to take the patient to the place where he or she is required to attend for treatment.
- Section 41(3): The police may be called to assist and may use *necessary* force to take the patient to the place where he or she is required to attend for treatment.
- Section 112(2): A warrant may be issued authorising the police to apprehend a patient who refuses to attend and to take the patient to the place specified for treatment. The police are not empowered to enforce treatment.

12.2 Community treatment versus inpatient treatment

There are several important distinctions between a compulsory community treatment order and a compulsory inpatient treatment order. Under a community treatment order:

- treatment is not in a hospital (but may be in a residential hostel or other community setting, including the patient’s home)
- no power to detain the patient for the purposes of treatment is given. Note that under section 40 of the Act, the DAO may take ‘all reasonable steps to take the patient to the place where the patient is required to attend for assessment or treatment’. Under section 41 of the Act the DAO may call the police for assistance.
- the scope of treatment should be clearly specified in the order (see 12.3 below). A treatment plan may include a specific residential requirement, but in the absence of any power to detain this is difficult to enforce.

Increasingly, there is a blurred boundary between inpatient and community facilities. For example, in moving towards community care for patients who have been in hospital under inpatient orders, community facilities may be planned that will provide a high level of care equivalent to that provided in a hospital setting. Thus, it may be tempting to view the provisions of a community order and an inpatient order as much the same, but in a different setting. This is not the case. A community treatment order should not be used as a basis for de facto detention in a community facility, although a high degree of supervision may be provided in some residential settings. A clear distinction must be maintained between a hospital (in which detention is authorised) and other facilities (in which it is not).

In some cases, the ‘treatment’ of an individual patient may include placement in a particular community setting. There has been some confusion over whether a responsible clinician can direct a patient subject to a community treatment order to live in a specified place. This issue is discussed in *Department of Health [sic] v D* (1999) 18 FRNZ 233; NZFLR 514, in which Judge Robinson found that there is no statutory power for a responsible clinician to direct where a patient resides while on a community treatment order for the purposes of treatment, ie, where the patient should live in the community.

However, it is the Ministry of Health’s view that 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. Therefore the need to clearly specify the terms and conditions of a community treatment order (this applies equally to section 31 leave) is strengthened when a responsible clinician applies to a Court for the granting of a community treatment order.

12.3 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.

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 necessary. 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.
- 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 a reassessment under section 29(3) of the Act.

12.4 Informal admissions during the term of a community treatment order

From time to time, a patient subject to a community treatment order may require and agree to, or seek an informal admission to hospital for treatment of his or her mental disorder. Because prolonged admissions to hospital appear to contradict the notion of community treatment, it is inappropriate to consider admission for more than a short period. In order to ensure that consent to such admission is informed and that reassessment under section 29(3) of the Act is used when appropriate, the following requirements should be met.

- An informal admission during the term of a community treatment order should occur only with the patient's fully informed consent, preferably in writing.
- Whenever a patient is admitted informally during the term of a community treatment order, the District Inspector must be notified. The District Inspector should check that the patient consents to the admission.
- 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 from the community treatment order and/or reassessing the patient under section 29(3) of the Act.
- If while the patient is informally admitted, consent is withdrawn or the patient is sufficiently unable to give consent at any time, the compulsory assessment and treatment process should recommence.

12.5 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 up to 14 days without the need to begin the assessment process and nullify the community treatment order. 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.

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 more than two 14 day periods as an inpatient during six months of the community treatment order, the responsible clinician must reassess the patient in accordance with sections 13 and 14 of the Act.

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

The patient continues to have the right to a review under section 79 of the Act by the Review Tribunal in respect of the existing order, and any finding by the tribunal relates only to the existing order.

13. SECTION 31: LEAVE FOR INPATIENTS

Section 31 of the Act provides for a patient's responsible clinician to grant leave for a period of up to three months. This period may be extended by a further three months. However, the Act is unclear about when it is necessary to specify terms and conditions of leave in writing. Various services have developed protocols for such situations. Where practicable, it is suggested that 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.

14. SECTION 35: RELEASE FROM COMPULSORY TREATMENT ORDER

There have been instances where patients have been released from compulsory treatment orders on verbal advice only. 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.

15. SECTION 38: ASSISTANCE WHEN A PERSON MAY NEED ASSESSMENT

15.1 The responsibilities of a DAO if a member of the public is concerned that someone he or she knows may be mentally disordered

Section 38 of the Act allows anyone who has concerns about a person's mental health to request the assistance of a DAO. The section also sets out specific chronological steps that a DAO must take to investigate the validity of the request.

A DAO who receives a request for assistance must investigate the matter to the extent that it is necessary to satisfy himself or herself that:

- the person making the request has genuine concerns
- there are reasonable grounds for believing that the person to whom the request relates may be mentally disordered.

In determining if there are a reasonable grounds for believing that the person may be suffering from a mental disorder and that the request is genuine, a DAO should consider the following:

- has the person been a mental health consumer at any time
- any psychiatric notes that the person may have
- the type and duration of the relationship between the person requesting assistance and the person who may be mentally disordered

- any recent contact the person may have had with the police or the local accident and emergency service.

If the DAO decides that the person should be assessed but that the situation is not urgent, section 38(3) of the Act requires a DAO to arrange (or assist in arranging) a medical examination for the person. If applicable, he or she should also arrange an assessment examination to take place under section 10 of the Act.

If the circumstances are urgent, section 38(4) of the Act requires a DAO to ensure that a medical examination (section 8B(4)(b)) takes place and arrange for an examination under section 9 of the Act.

It is preferable that a DAO arranges for a medical practitioner to come to the person for the purposes of the medical examination (section 38(4)(a) and (b)). However, if a medical practitioner is not available and the person refuses to go willingly to a medical practitioner, a DAO can take all reasonable steps to take the person to a medical practitioner and ensure that a medical practitioner is able to examine the person. This may include requesting police assistance under section 41 of the Act (section 38(4)(d)).

DAOs should be aware that the Code of Rights applies to all people receiving health or disability services (including those to whom an application under section 8B or a request under section 38 of the MH (CAT) Act relates) and that providers are obliged to take action to inform consumers of those rights (regulation 1(3)(a) of the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996).

Once a person becomes a proposed patient, the rights set out in sections Part VI of the MH (CAT) Act also apply.

During the assessment process (and during a compulsory treatment order once a second opinion has been obtained under section 59) people (to whom an application under section 8B or a request under section 38 relates), proposed patients, and patients do not have the right to refuse assessment, transport or treatment.

The fact that Right 7 of the Code of Rights gives consumers the right to informed choice and informed consent may cause consumers some confusion. DAOs acting under section 38 should explain to consumers that they may not refuse compulsory assessment and treatment or transport (for the purposes of a medical examination – section 38(4)(d)). However, DAOs should ensure that consumers are fully informed about any proposed course of action.

15.2 The action a DAO should take if the person is not considered to be mentally disordered

DAOs are first and foremost competent mental health professionals and should deal with any situation in accordance with their clinical judgement and usual professional standards, whether or not it is necessary to invoke the procedures of the Act.

A DAO might investigate a request for assistance and consider that there are no reasonable grounds for believing the individual to be mentally disordered within the meaning of the Act

and that no further action is required under the Act. Acting as a clinician, the DAO should then assess the individual and his or her situation and take whatever further action is appropriate. As in any other situation, an appropriate record of the assessment and action taken should be made.

15.3 What a DAO should do in a situation where the DAO believes that an individual is mentally disordered but the medical practitioner who has examined the person disagrees

DAOs are appointed on the basis of their expertise in dealing with individuals who are mentally disordered. It is possible that in certain situations the DAO may have more expertise in the assessment of mental disorder than the medical practitioner. In such a situation, the DAO must use his or her clinical judgement as to the likely risk to the individual or to others and the urgency of the matter.

The options are either to accept the medical judgement and reassess the situation as appropriate, or to seek another medical opinion. A DAO who is concerned about an individual in this situation should discuss the matter with the psychiatrist on duty or the DAMHS.

The DAO should make a full and accurate record of the assessment and any action taken.

DAOs are usually members of an emergency psychiatric team and can be contacted via local hospital or health services.

16. SECTION 40: ASSISTANCE IN TAKING OR RETURNING A PROPOSED PATIENT OR PATIENT TO THE PLACE OF ASSESSMENT OR TREATMENT

Under section 40 of the Act, a DAO may take all reasonable steps to take a patient or proposed patient to a place he or she is required to attend or to return a patient to hospital.

The section also applies to:

- every patient or proposed patient who is refusing to attend at any place required for:
 - an assessment examination under section 9 of the Act
 - assessment in accordance with sections 11 or 13 of the Act
 - an examination by a Judge under section 18 of the Act
 - a clinical review under section 76 of the Act
- every patient who is subject to a community treatment order and who is refusing to attend at a place for treatment in accordance with the order

- every patient who is subject to an inpatient order and is absent without leave or whose leave of absence has expired or been cancelled.

17. SECTION 41: POLICE ASSISTANCE

Section 41 of the Act enables a DAO to seek police assistance when attempting to do anything specified in sections 38 or 40 of the Act.

Section 41 also sets out the responsibilities of a member of the police if called to assist a DAO. Under section 41 of the Act, a member of the police:

- can enter the premises where the patient or proposed patient is
- must identify himself or herself with a badge or other evidence if not in uniform
- may not detain a proposed patient for the purposes of section 38(4)(b) or sections 40(1)(a) or (b) of the Act for any period of time longer than that which is the shorter of six hours and the time it takes to conduct the medical examination or review
- may take the patient back to hospital for the purposes of section 40 of the Act
- may not enter any premises under section 41(2) of the Act without a warrant, if it is reasonably practicable to obtain a warrant.

In determining if it is reasonably practicable for Police to obtain a warrant for the purposes of entering any premises, the urgency of the circumstances would need to be considered.

18. SECTION 44: TREATMENT OF SPECIAL PATIENTS

A special patient is a person who is governed by the sections of legislation listed below:

- section 171(3) of the Summary Proceedings Act 1957
- section 115(1) of the Criminal Justice Act 1985 (the Criminal Justice Act)
- section 115(4) of the Criminal Justice Act
- section 121(2)(b)(ii) of the Criminal Justice Act
- section 121(11) of the Criminal Justice Act
- section 45(2) of the Act
- section 46 of the Act.

18.1 Right to treatment

Special patients shall be given the same care, treatment, training and occupation as the patient would be given if he or she were subject to a compulsory treatment order (section 44). This

includes the right to ‘medical treatment and other health care appropriate to his or her condition’ (section 66).

18.2 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 121 of the Criminal Justice 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)) and thereafter if a psychiatrist (not being the responsible clinician) appointed by the Review Tribunal considers that the treatment is in the patient’s best 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 where the patient is unable to consent (see 18.5 below).

18.3 Special patients admitted under section 46

Special patients admitted under section 46 of the 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 where the patient is unable to consent (see 18.5 below).

18.4 Special patients detained in hospital under an order pursuant to section 121 of the Criminal Justice Act 1985

Special patients detained in hospital pursuant to an order made under section 121 of the Criminal Justice Act for the purpose of a psychiatric examination are subject to section 121(9) of the Criminal Justice Act. This provision declares an order under section 121 of the Criminal Justice Act to be sufficient authority for administering to a defendant who is incapable of giving consent ‘such medical treatment or procedures as, in the opinion of [the medical practitioner responsible for the care of the patient], are immediately necessary to prevent the physical or mental deterioration of the defendant or serious suffering by the defendant, or to prevent the defendant causing harm to himself or to others’.

There are many cases in which this degree of urgency is not present, but where it is nevertheless clear that compulsory treatment for mental disorder is required. The appropriate course of action in such cases is to use the Act and the Criminal Justice Act together. This is clearly in the best interests of the patient, and will ensure that all the safeguards for the rights of the patient that are provided under the Act are in place.

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 an order pursuant to section 121 of the Criminal Justice Act does not, in itself, provide reasonable grounds for believing that he or she is not competent. Furthermore, the Code of Rights notes that even where an individual has diminished competence, he or she

‘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)).

18.5 Non-consensual emergency treatment

Common law permits medical treatment to be administered to any patient who is unable to consent to such treatment, in an emergency. This exception is recognised in right 7(1) of the Code of Rights. It applies to special patients, like any other patient. Furthermore, section 62 of the 1992 Act effectively preserves the common law right to administer any medical 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’.

18.6 Treatment of prisoners transferred from prison

18.6.1 Section 45

From time to time, mental health services have raised the matter that patients admitted to hospital under section 45 of the Act cannot continue to be treated compulsorily on their return to prison. For some individuals, this results in repeated admissions to hospital. There are several options that are available to mental health services.

The Act provides for compulsory assessment and treatment in the case of individuals who experience mental disorder, ‘whether of a continuous or intermittent nature’. Consideration should be given to whether such individuals should remain in the care of forensic psychiatric services.

18.6.2 Section 46

Section 46 of the Act may be used to provide treatment for individuals who, although not mentally disordered, require psychiatric treatment. This section requires the consent of the patient, and may be used for those individuals who no longer require the compulsion of the Act, but who would be particularly vulnerable if returned to prison.

18.6.3 Treatment while in prison

Of course, treatment may be given to people in prison with their informed consent. Clinicians need to work with patients to gain their trust and increase understanding of their illness and the need for treatment. Effective liaison between forensic services and prisons will assist in encouraging patients to continue treatment after return 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 co-operation among providers to ensure quality and continuity of services.

18.7 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.

19. SECTIONS 54 TO 56: 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 a patient who ‘presents special difficulties because of the danger he or she poses to others’. Such patients must be subject to an inpatient order, but need not necessarily have entered the mental health services by way of the criminal justice system. Having said this, many such patients will have a long history of contact with forensic services, and may have previously been detained as special patients. It is expected that restricted patients will be managed by the forensic psychiatric services.

The ‘restrictions’ imposed on such patients are the same as those applying to special patients. That is, they are not permitted leave without the approval of the Director of Mental Health, and the patient cannot be released from restricted patient status solely by his or her 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.

Applications for restricted patient status should be made to the Director of Mental Health, and should contain the following information:

- the patient’s psychiatric history and diagnosis
- the history of dangerousness and any previous offending, including information on the relationship between that individual’s mental disorder and patterns of offending/re-offending
- information on the reasons why the patient cannot be managed under an inpatient order, including comments outlining the risks posed by the patient
- an opinion on the recommended treatment and management options for the patient over the next year
- if possible, comments about the length of time that the individual may need to remain a restricted patient.

Each application must be accompanied by a second opinion, either from the Director of the Regional Forensic Psychiatric Service or an experienced forensic psychiatrist. The DAMHS may wish to add his or her comments to the application.

20. SECTIONS 57 TO 59: LIMITS OF NON-CONSENSUAL TREATMENT

20.1 Non-consensual treatment

A patient who is subject to a compulsory treatment order 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)) and thereafter if a psychiatrist (not being the responsible clinician) appointed by the Review Tribunal considers that the treatment is in the patient’s best interests (section 59(2)(b))¹². In all other cases (except emergency treatment where the patient is unable to consent: see 20.2 below), a patient’s written informed consent to treatment must be obtained (section 59(2)(a)) and may be withdrawn at any time (section 63).

Particular care should be taken to scrutinise whether the patient is competent to give informed consent to the proposed intervention. The usual presumption of competence does not apply if ‘there are reasonable grounds for believing the [patient] is not competent’ (right 7(2), Code of Rights). Non-consensual treatment of special patients is discussed in 18.2 above.

If a patient is not competent to consent to treatment for mental disorder, the approval of a psychiatrist appointed by the Review Tribunal must be obtained under section 59(2)(b) of the Act.

Note that the word ‘treatment’ should not be given a narrow interpretation but includes all the remedies that health professionals have available to them to manage mental illness (see *CCH v R* (1995) 13 FRNZ 294). It is important to note that electroconvulsive treatment (ECT) and brain surgery cannot be given in an emergency.

20.2 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 1992 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’.

21. SECTION 60(A): CONSENT TO ELECTROCONVULSIVE TREATMENT

The Act requires that electroconvulsive treatment (ECT) may be given *either* with the written consent of the patient *or* if it is considered to be in the best interests of the patient by a psychiatrist appointed by the Review Tribunal. Due consideration of sections 5 and 6 of the Act regarding ECT is essential for patients of different ethnic backgrounds, particularly Māori.

Those who require ECT are, by clinical opinion, unwell. Although consent may apparently be freely given, the patient’s understanding of the treatment can often be impaired by illness, and

¹² Except in the case of electroconvulsive treatment and brain surgery.

the individual may be ambivalent about ECT. In these circumstances there may be doubt as to whether consent is informed and freely given. 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. Patients should also be informed of alternative treatments and the likely consequences of not accepting treatment. Explanations should be translated into the first language of the patient, either in writing or verbally (section 6). The patient may withdraw consent to ECT at any time (section 63).

22. SECTIONS 64 TO 75: RIGHTS OF PROPOSED PATIENTS AND 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 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 the right to receive/send and post articles unnecessary.

The rights in sections 64 to 75 of the Act supplement the rights affirmed in the New Zealand Bill of Rights Act 1990 (the Bill of Rights Act) 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 Bill of Rights Act and the Code of Rights as far as possible. Of particular relevance is section 23(5) of the Bill of Rights Act, which affirms that ‘everyone deprived of liberty shall be treated with humanity and respect for the inherent dignity of the person’.

22.1 Section 64: General rights to information

In addition to receiving information about proposed treatment (see 22.4 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 Bill of Rights Act 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.

22.2 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 (refer to comments on sections 5, 6, and 7A of the Act).

22.3 Section 66: Right to treatment

As a corollary to the compulsory nature of assessment and 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 (ie, for health conditions not related to the mental disorder).

22.4 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 consumer, in that consumer’s circumstances, would expect to receive (rights 6(1) and 6(2), Code of Rights).

Obviously the quantity and quality of the information given will depend on the exigencies of the situation. However, even when treatment is given non-consensually (see 20.1 and 20.2 above), patients should be told what is proposed, although in an emergency it may be possible to give only a limited explanation of what is happening. 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). 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’.

22.5 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 where it is intended to record (either on video or audio tape) the treatment of a patient.

Note that rule 4 of the Health Information Privacy Code 1994 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.

22.6 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.

22.7 Section 70: Right to legal advice

Services should ensure that satisfactory arrangements have been made with the local District Law Society (DLS) to ensure that a patient or proposed patient can obtain the services of a lawyer if he or she does not already have a lawyer. This can be facilitated by obtaining from the DLS 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 Bill of Rights Act ‘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.

22.8 Section 71: Right to company and seclusion

It may become necessary for a patient or a proposed patient to be secluded for his or her 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 *Procedural Guidelines for the Use of Seclusion* (Ministry of Health, revised edition 1995) should be adhered to. Assessment of a proposed patient should be conducted as a matter of urgency in such circumstances.

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

This section equally applies to proposed patients or patients. There will be some cases where a proposed patient wishes to advise others of his or her compulsory assessment under the Act and to make personal arrangements. Where it is safe to do so, the proposed patient should be given access to a telephone.

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

These sections are self-explanatory and do not apply to proposed patients because of the short duration of the assessment period.

22.11 Section 75: Complaint about a breach of rights

Although section 75 of the Act confines the District Inspectors’ complaints investigation jurisdiction to breaches of the rights conferred on patients by sections 64 to 74 of the Act, in practice the District Inspectors may also investigate complaints about events occurring while the patient was still a proposed patient. Authority for this extended jurisdiction may be found in section 95(1)(b), which gives District Inspectors discretionary power to inquire into ‘such other matters as the District Inspector ... thinks fit to be inquired into respecting any patients’.

Patients and proposed patients may also 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 a Police Complaints Authority (PCA) specifically to investigate allegations of misconduct or neglect of duty by police. The PCA has primary jurisdiction in that area.

23. PART VIII: CONSENT FOR YOUNG PEOPLE AND INVOLVEMENT OF FAMILY/WHĀNAU

Part VIII 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.

There are several key points to note.

- 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 he or she has 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 inform the patient about the treatment (risks and side effects) is not displaced by the fact that a parent or guardian is giving the consent to treatment.

24. SECTION 99B: DELEGATIONS BY PERSON IN CHARGE OF A HOSPITAL

The person in charge of a hospital can delegate his or her powers under the Act to another person who is suitably qualified. The delegation must be in writing, and revocation of the delegation must also be in writing. It is recommended that the delegation to admit or detain a

patient or proposed patient be delegated to a person who has a clinical background, for example members of a psychiatric crisis team and/or designated staff in an acute psychiatric unit.

25. SECTION 110: POWERS OF A MEDICAL PRACTITIONER WHEN AN URGENT MEDICAL 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.

26. 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 himself or herself or to others and that it is in the proposed patient's best interests to receive a sedative drug urgently. The medical practitioner may administer the drug, and if he or she does so it must 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.

Where a medical practitioner administers a sedative drug, he or she 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.

27. 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.

28. 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 an assessment examination, a person who has been admitted to hospital (or who has been brought to a

hospital) who is believed to be mentally disordered. 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 of the Act does not necessarily apply in every situation in which assessment under the Act is initiated in respect of a person already in the hospital – it is intended for use only in an emergency. Informal patients can be placed under the inpatient assessment process in the same way as any other person.

29. SECTION 113: AUTHORITY OF THE PERSON IN CHARGE OF A HOSPITAL OR SERVICE TO ADMIT AND 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 under sections 11 and 13 of the Act
- 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 the shorter of 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 the standards laid down in the relevant Ministry of Health guidelines (refer to *Procedural Guidelines for Physical Restraint* (Ministry of Health 1993) and *Procedural Guidelines for the Use of Seclusion* (Ministry of Health revised edition 1995)). 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.

The question arises as to whether ‘detention’ applies only within the hospital premises. This is normally the case (note that ‘hospital’ is not limited to a psychiatric ward). However, it would be reasonable to intercept and detain a person who is actively suicidal and attempting

to abscond from the hospital if he or she was outside the hospital gate during the act of absconding. Staff should act with common sense and in accord with good professional practice in such a situation. However, where individuals have 'made good their escape', the matter should be dealt with as an 'absence without leave' situation.

30. SECTION 113A: A JUDGE OR REGISTRAR MAY ISSUE WARRANTS

This section authorises a District Court Judge or Registrar to issue a warrant authorising the police to apprehend any person who refuses to attend for an assessment examination as instructed by notices under sections 9, 11, 13, 18, or a hearing under section 19 of the Act or a clinical review under section 76 of the Act. The 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. Section 113A of the Act does not confer a general power to seek a warrant for the apprehension of any person who is not co-operating with mental health services or hospital authorities.

31. 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
- detain
- enter premises.

Force as is reasonably necessary in the circumstances may also be used under section 122B(3) at any time for the purposes of treatment.

Before force is used it is strongly recommended that the use of de-escalation skills should always be considered, and if clinically appropriate used.

When force is used, a log recording the exact circumstance must be completed. A log for this purpose should include:

- the date, time, and place that force was used
- why force was required
- 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.

This log must be forwarded to the DAMHS as soon as practicable.

Where any use of force is authorised, any person using force is criminally responsible for any excess (see section 62 of the Crimes Act 1961).

Services should refer to the Memorandum of Understanding between the New Zealand Police and the Ministry of Health (see pages 61-64), which provides guidance to police staff and health professionals administering the provisions of the Act.

32. SECTION 114: NEGLECT OR ILL-TREATMENT OF PROPOSED PATIENTS OR PATIENTS

It is an offence under the Act to intentionally neglect or ill-treat patients or proposed patients who may be or who are mentally disordered as defined by the Act.

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.

33. THE VICTIMS OF OFFENCES ACT 1987

33.1 The effect of section 11A of the Victims of Offences Act 1987

Consequential amendments to the Victim of Offences Act 1987 (the Victims of Offences Act) were made via amendments to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act). Section 11A, which relates to compulsorily detained persons, came into force on 1 April 2000.

Section 11A of the Victims of Offences Act relates to victims of an alleged offence or offence of sexual violation or other serious assault or injury by a compulsorily detained person (patient or special patient) governed by the sections of legislation listed in 33.2.1 below.

Under the Victims of Offences Act, a victim may apply to be notified of:

- any escape of a patient or special patient
- any impending discharge of the patient or special patient
- long leave granted to the special patient by the Minister of Health under section 50 of the Act.

If the victim's application for notification is successful, the victim will be registered on the national Victim Notification Register, which is administered by the Department of Corrections.

33.2 Definitions

33.2.1. *Patient or special patient*

Special patients¹³ to whom the amendment applies are those governed by the sections of legislation listed below:

- section 171(3) of the Summary Proceedings Act 1957: a defendant who is committed for trial or for sentence/or detention in a psychiatric hospital pending trial and who is released on bail
- section 115(1) of the Criminal Justice Act 1985 (Criminal Justice Act): a person who is detained as a special patient having been acquitted on account of his or her insanity *or* is found to be under disability
- section 115(4) of the Criminal Justice Act: a person who is remanded to hospital for seven days while the Court decides which order to make under section 115 of the Criminal Justice Act
- section 121(2)(b)(ii) of the Criminal Justice Act: a person remanded to hospital for a psychiatric report (for a period of 14 days)
- section 121(11) of the Criminal Justice Act: a person remanded to hospital pending trial
- section 45(2) of the Act: a person detained in prison who is transferred to hospital for compulsory psychiatric assessment and/or treatment
- section 46 of the Act: a person detained in prison who is transferred to hospital for voluntary psychiatric assessment and/or treatment.

Patients¹⁴ to whom the amendment applies are those governed by the sections of legislation listed below:

- section 115(2)(a) of the Criminal Justice Act: a person who is detained under an inpatient compulsory treatment order having been acquitted on account of his or her insanity *or* when found to be under disability

¹³ Note that special patients are subject to particularly restrictive provisions set out in the Act.

¹⁴ Patients are also governed by provisions in the Act but those provisions are less restrictive than ones governing special patients.

- section 118 of the Criminal Justice Act: a person convicted of an offence and for whom the court has ordered an inpatient compulsory treatment order instead of a prison sentence.

33.2.2 Victim¹⁵

A victim is a person who, through or by means of a criminal offence (whether or not any person is convicted of that offence), suffers:

- physical or emotional harm
- loss of or damage to property

and, where an offence results in death, the term includes the members of the immediate family of the deceased.

33.2.3 Escape

Escape means that a patient or special patient is absent from the hospital grounds without approved leave. It also applies to a patient or special patient who is on approved leave and fails to return from that leave.

33.2.4 Impending discharge

Any impending discharge should be taken to mean:

- the first period of unescorted short-term leave from the hospital granted to a special patient under section 52 of the Act¹⁶
- the first period of unescorted leave granted to a patient under section 31 of the Act
- any relevant change of legal status granted to the patient or special patient.

Short term leave can be for a matter of hours or for up to seven days.

Change of legal status is when a patient or special patient ceases to be governed by a certain section of legislation. It may follow that such a patient is then governed by a different section of legislation. There are four different things that can happen to the patients and special patients covered by section 11A of the Victims of Offences Act when their legal status changes. These are outlined below.

- For special patients subject to section 115(1) of the Criminal Justice Act: they cease to be subject to an order made under the Criminal Justice Act 1985 and become a 'patient' subject to an inpatient compulsory treatment order under the Act.

¹⁵ See section 2 of the Victims of Offences Act 1987.

¹⁶ Note that special patients under sections 121(1)(2)(b)(ii), 121(11), 115(4) of the Criminal Justice Act 1985 (CJA) and section 171(3) of the Summary Proceedings Act 1957 are not eligible for short-term leave granted under section 52 of the Act.

- For special patients on remand awaiting trial (sections 121(11), 121(2)(b)(ii) and 115(4) of the Criminal Justice Act and section 171(3) of the Summary Proceedings Act): the person is sent back to Court for trial or to prison to await trial.
- For special patients subject to sections 45 or 46 of the Act: they are either sent back to prison or, if their sentence ends while in hospital, they become a ‘patient’ subject to an inpatient compulsory treatment order under the Act.
- For patients subject to sections 115(2)(a) or 118 of the Criminal Justice Act: they cease to be subject to an inpatient compulsory treatment order under the Act and become a ‘patient’ subject to a community treatment order under the Act or are released.

33.2.5 Long leave

Long leave is leave from the hospital granted by the Minister of Health to a special patient under section 50 of the Act.¹⁷ The period of leave is usually six months, but may be up to 12 months. The special patient is placed in the community, and must comply with strict conditions outlined in a warrant signed by the Minister of Health.

33.2.6 Deactivation of victim notification request status

A victim notification request is deactivated when:

- a special patient’s legal status is changed,¹⁸ unless the change in legal status has resulted in their transfer to prison or back to Court for trial (see 33.2.4)
- a patient’s legal status is changed (see 33.2.4).

33.3 The registration process for victims

33.3.1 Application

A victim can apply to the Department of Corrections to become a ‘registered victim’. This is done by completing an application form distributed by the Department of Corrections and New Zealand police. Leaflets can be ordered from the Department of Corrections, Private Box 1206, Wellington, or by contacting the local Victim Support Service or police station.

33.3.2 Verification

When the Department of Corrections receives an application for the Victim Notification Register (VNR), the application is forwarded to the police. The police identify those persons who are eligible for notification under section 11 and 11A of the Victims of Offences Act. To do this, the police check that:

¹⁷ Section 50 applies only to special patients under section 115(1)(b) of the CJA (those found not guilty by reason of insanity), and sections 45 and 46 of the Act.

¹⁸ Note that when an offender subject to a prison sentence is no longer subject to that sentence, the victim notification request is deactivated.

- the offence/alleged offence has occurred
- the correct offender/alleged offender has been identified
- the applicant is a ‘victim’ as defined by section 2 of the Victims of Offences Act.

Within 10 working days of receipt of the police verification, the Department of Corrections writes to every person who has submitted an application advising him or her of the outcome of the verification process.

If the police verify the application, the applicant becomes a ‘registered victim’ and his or her request and relevant information is entered in the national VNR.

If police are unable to verify an application because the criteria set out above are not met, the applicant will be informed by the Department of Corrections. They will be told why their application has been unsuccessful and that they have a right of appeal. Applicants can appeal by writing to the National Co-ordinator, Victim Notification Register, at the Department of Corrections.

33.3.3 Offenders/alleged offenders detained in mental health services

If the offender/alleged offender is not detained in a prison, the Department of Corrections will liaise with the Director of Mental Health, Ministry of Health, to inquire if the offender/alleged offender is a patient or special patient compulsorily detained in the care of mental health services.

If it is confirmed that the offender/alleged offender is in the care of a particular mental health service, the Department of Corrections will notify the Health VNR Co-ordinator at the relevant mental health service that there is an active victim notification request for a specific patient. The Health VNR Co-ordinator will enter the victim’s information onto the local VNR database.

33.4 Initial information provided once an application for notification is approved

33.4.1 Information provided to the victim

If the victim is eligible to become a registered victim under section 11A of the Victims of Offences Act, the Department of Corrections will send the victim an information pack so that the victim will better understand the type of notifications he or she may receive about the patient in the future. The pack will include information about:

- the Act
- the Criminal Justice Act
- special patients
- special patient rehabilitation

- leave processes for patients.

33.4.2 Information provided to the patient

The patient will receive no information about the registered victim.

It is recommended that Hospital and Health Services inform all patients (and their family/whānau) affected by a victim notification request:

- what the victim notification register is
- how the register is administered.

33.5 Administration of a victim notification register in mental health services

33.5.1 Responsibility for administering a victim notification system

DAMHSs are responsible for the administration of the Act at the Hospital and Health Service level. Therefore, it is expected that each DAMHS will ensure that the Hospitals and Health Services he or she is responsible for will have an appropriate victim notification system in place. It is envisaged that the VNR will mostly affect regional forensic psychiatry services.

33.5.2 Appointment and role of a Health VNR Co-ordinator

The Health VNR Co-ordinator is responsible for administering and co-ordinating the VNR at the Hospital and Health Service level. Each mental health service should have a Health VNR Co-ordinator for victim notification, and one other person acting as back-up.

33.5.3 Confidentiality

The victim's confidentiality is paramount to the safety and effectiveness of the VNR. It is vital that mental health services maintain the integrity of victim's details at all times. The following are safeguards for ensuring that the victim's details remain confidential.

- Victim details such as name and address should be kept on a confidential file by the Health VNR Co-ordinator.
- The Health VNR Co-ordinator should 'tag' the patient's file to show that a victim notification request exists, but none of the victim's details should appear on the patient's file.
- It is strongly recommended that mental health services keep the victim's details completely separate (in a different location) from the patient's file.
- The Ministry of Health will also keep a confidential record of each victim notification request for back-up purposes only.

- Only two staff members in the mental health service should have access to the victim's details. These are the Health VNR Co-ordinator and one back-up person.
- All staff involved in the patient's care should be alerted to the existence of a victim notification request, but none of the victim's details should be given to staff other than the Health VNR Co-ordinator and the back-up person.

33.6 Information to be given to registered victims under certain circumstances

The Health VNR Co-ordinator must give the information outlined in the schedule below to registered victims in the circumstances outlined. At no time should a patient's clinical and personal information be divulged to a victim.

Notification may include information about the patient's *general* geographic location but should not contain any specific geographic details or clinical details.

Schedule of information to be given to registered victims in certain circumstances

Event (circumstance)	Action (information to be given to registered victims)
Escape and/or return	Immediate telephone advice followed by written confirmation, when a patient or special patient escapes from the service, or is returned.
Granting of unescorted short-term leave (sections 31 or 52 of the Act)	Written confirmation of the commencement of unescorted short-term leave 10 working days prior to the date the leave occurs. Victims are informed the first time unescorted leave is granted, not every time unescorted leave takes place. Where there is insufficient time, for example where an application is received late, immediate notification by telephone is required. Such telephone advice must be confirmed in writing. It must also include advice about conditions imposed on all leave, for example non-contact with victims. ¹⁹

¹⁹ Note that the information pack for victims will give details about special patient and patient rehabilitation processes and the fact that victims will be told when the unescorted leave part of a rehabilitation programme begins (but not each progression of it).

Granting of Ministerial long leave (section 50 of the Act)	Written confirmation of the granting of Ministerial long leave to the special patient 10 working days prior to the date the long leave commences. Where there is insufficient time, for example where an application is received late, immediate notification by telephone is required. Such telephone advice must be confirmed in writing. It must also include advice about conditions imposed on all leave, for example non-contact with victims.
Changes to leave conditions - unescorted leave and Ministerial long leave	Written advice about any changes to a patient or special patient's leave conditions. Immediate telephone advice is required where the change results in a new leave provision, for example revocation of leave. Telephone advice must be confirmed in writing.
Change of legal status	Written advice about any change of legal status including the date, at least 10 working days prior to the first day of change in legal status. If there is insufficient time, immediate telephone advice is required followed by confirmation in writing. This advice should include the general location in which the patient or special patient will be living in but not the actual address (for example, " <i>to the Dunedin metropolitan area ...</i> "). At the time a patient or special patient's legal status is changed, the victim notification request ceases to have effect (see section 33.2.6). This should be made clear to the victim when he or she is notified of the change of legal status.

Rule 11(2)(d) of the Health Information Privacy Code 1994 is not altered. Rule 11(2)(d) enables health information to be given to prevent or lessen a serious and imminent threat to public health or public safety; or the life or health of the individual told or another individual.

33.7 Further responsibilities of a Health VNR Co-ordinator

33.7.1 Confidential transferral of the registered victim's details

If the patient or special patient is transferred to another mental health service or to a prison, the transferring Health VNR Co-ordinator is responsible for ensuring that:

- the victim's details are transferred separately from the patient or special patient's details
- the victim's confidentiality is maintained.

33.7.2 Notification of the Ministry of Health

The Health VNR Co-ordinator should inform the Director of Mental Health of:

- any escape of the patient or special patient
- any leave granted to the patient²⁰
- any transfer of the patient or special patient.

33.7.3 Notification of the Department of Corrections

The Health VNR Co-ordinator should inform the Department of Corrections of:

- any transfer of the patient or special patient; or
- any change in legal status of the patient or special patient.

33.8 Deactivation of the victim notification request

When the patient or special patient is granted a change of legal status (see section 33.2.6), the Department of Corrections will deactivate the victim notification request and close the patient or special patient's VNR file.

If the registered victim decides that he or she no longer wishes to be notified in accordance with section 11A of the Victims of Offences Act, he or she may also deactivate his or her notification request at any time by contacting the National Co-ordinator, Victim Notification Register, at the Department of Corrections.

33.9 Clarification of the roles of the Ministry of Health, New Zealand Police, and the Department of Corrections

Currently the Ministry of Health, New Zealand Police, and the Department of Corrections are working on a Memorandum of Understanding to clarify each agency's roles and accountabilities in relation to the administration of the Victim Notification Register.

²⁰ Note that the Director of Mental Health is responsible for granting short-term leave to special patients and for co-ordinating the approval, by the Minister, of long term leave under section 50. The Director will need to be informed when responsible clinicians grant leave under section 31 of the Mental Health (CAT) Act to patients under section 118 and 115(2)(a). When notifying the Director, responsible clinicians should also provide a proposed clinical management plan.

OTHER GUIDELINES AND DOCUMENTS PUBLISHED BY THE MINISTRY OF HEALTH

- *Procedural Guidelines for the use of Seclusion* (revised edition June 1995)
- *Night Safety Procedures* (June 1995)
- *Guidelines for Reducing Violence in Mental Health Services* (February 1994)
- *Procedural Guidelines for Physical Restraint* (June 1993)
- *Guidelines for the Management of Patients with Co-existing Psychiatric and Substance Use disorders* (January 1994)
- *A Guide to effective Consumer Participation in Mental Health Services* (April 1995)
- *Guidelines for Cultural Assessment in Mental Health Services* (July 1995)
- *Guidelines on the Management of Suicidal Patients* (July 1993)
- *Guidelines for Prescribing Psychotropic Drugs* (February 1996)
- *Guidelines for the Assessment and Treatment of Pathological Gambling* (June 1996)
- *Guidelines for Discharge Planning for People with Mental Illness* (July 1993)
- *Guidelines for Reporting and Review of Incidents in Mental Health Services* (December 1995)
- *Recommended Standards for Case Notes* (June 1992)
- *Measures to Improve the Quality of Incident Reporting* (June 1992)
- *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (July 1998)
- *Use of Antipsychotic Drugs for Adult Psychiatric Illness* (June 1992)
- *Guidelines for the Role and Function of Duly Authorised Officers under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000)
- *Guidelines for the Role and Function of Directors of Area Mental Health Services* (April 2000)
- *Guidelines for District Inspectors Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000)
- *Guidelines for Medical Practitioners Using Sections 110 and 110A of the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000).

MEMORANDUM OF UNDERSTANDING DATED 23/3/2000 BETWEEN NEW ZEALAND POLICE AND THE MINISTRY OF HEALTH

MEMORANDUM OF UNDERSTANDING

23/3/2000

BETWEEN

THE NEW ZEALAND POLICE
(hereinafter referred to as "the Police")

AND

THE MINISTRY OF HEALTH
(hereinafter referred to as "the Ministry")

RECITAL

IN recognising that the Police and the Ministry have separate missions and standards,

AND acknowledging that each party brings to its respective tasks valuable expertise and resources,

AND acknowledging full co-operation between both parties at all levels as essential to ensure the co-ordinated, effective and efficient delivery of services to meet the needs of individuals who may require compulsory assessment and treatment under the Mental Health (Compulsory Assessment and Treatment Act) 1992:

BOTH PARTIES DECLARE AND AGREE TO THE FOLLOWING

1 INTRODUCTION

- 1.1 The following matters are agreed in principle between the Police and the Ministry of Health to give guidance to Police staff and health professionals administering the provisions of the Mental Health (Compulsory Assessment and Treatment) Act, 1992, (hereinafter referred to as 'the Act').
- 1.2 This memorandum should form the basis of local agreements made at Police region and district level with Mental Health Services.
- 1.3 A spirit of co-operation should prevail in all dealings under the Act between Police and health professionals.
- 1.4 People being dealt with under the Act are **patients or proposed patients** and shall be treated with humanity and respect for the inherent dignity of the person. The responsibility for the provision of services under the Act to mentally disordered persons rests primarily with health services. It is further

recognised that such persons, while being dealt with purely under the Act, have not necessarily broken any rule of law.

- 1.5 Police and health professionals must retain a flexible approach to any incident being dealt with under the Act and must be prepared at all times to change their course of action.
- 1.6 Nothing in this Memorandum limits or prevents the Police from carrying out any duties or exercising any powers under other enactments.

2 RESPONSIBILITIES

- 2.1 The Duly Authorised Officer is the official in charge at any incident that requires the invoking of the Act and a combined Police/Mental Health Services response. In the absence of a Duly Authorised Officer if sections 110, 110A, 110B, or 110C are being invoked the Registered Medical Practitioner is the official in charge.
- 2.2 The Police may be called upon to assist the health professionals but will continually review the appropriateness of the action requested of them. The Police will advise the health professionals if the actions requested of them are outside their powers or immediate ability.
- 2.3 Duly Authorised Officer should only request Police assistance when the particular powers and specific expertise of the Police are required.

3 TRANSPORTATION OF PATIENTS

- 3.1 Duly Authorised Officers have the responsibility for arranging for the transportation of patients, proposed patients, and patients absent without leave. Mental Health Services are responsible for ensuring that Duly Authorised Officers are adequately resourced to carry out this duty.
- 3.2 When the particular powers and specific expertise of the Police are required to assist with transportation, the decision as to the type of vehicle to be used should be made by the Duly Authorised Officer or Registered Medical Practitioner in charge in consultation with attending Police.
- 3.3 Matters to be taken into account in making that decision include:
 - the clinical condition of the patient or proposed patient
 - whether sedation has been administered to the proposed patient or patient
 - the potential or actual violence of the patient or proposed patient
 - the types of vehicle available
 - the need for restraint and the type of restraint required
 - the personnel available
 - the distance to be travelled
- 3.4 Where Police have been called to assist a Duly Authorised Officer or Registered Medical Practitioner, the Duly Authorised Officer **OR** a suitable health professional will at all times **PHYSICALLY** accompany and monitor the patient or proposed patient. The definition of 'suitable health professional'

should be negotiated at a local level and be contained in local memoranda of understanding.

4 USE OF FORCE

- 4.1 Section 122B of the Act allows the use of force in certain circumstances. Anyone who is exercising a power under the Act should be certain that these circumstances apply before using force.
- 4.2 Any taking, retaking or detention by force must only be in circumstances where it is likely the patient or proposed patient will be a danger to him or herself, or to others or will be likely to cause serious property damage.
- 4.3 Before using force the wishes of the patient or proposed patient and their caregivers should be sought wherever practicably possible and careful consideration should be given to their views. Every effort must be made to reduce the risk of violence before the patient is transported.
- 4.4 If it is necessary to use force to take and/or detain a patient or proposed patient the Duly Authorised Officer or Registered Medical Practitioner shall give a clear request to police to do so.
- 4.5 If it is necessary to use force to gain entry to property in an emergency the Duly Authorised Officer or Registered Medical Practitioner shall give a clear request to Police to do so. Police officers must be certain of the section of the Act they are acting under that authorises the entry. Where it is reasonably practicable to get a warrant, the Police must comply with section 41(7). In determining whether it is reasonably practicable to apply for a warrant, Police should consult with the Duly Authorised Officer or Registered Medical Practitioner. The appropriate Mental Health Service should usually assume responsibility for making good any damage caused by such action.

5 CHARGING FOR SERVICES

- 5.1 The Police and the respective Mental Health Services will not normally charge each other for the provision of assistance under the Act.
- 5.2 Consideration may be given to charging for pre-planned use of Police services by Hospitals and Health Services where it has been contractually agreed to at a local level or in instances of excessive and unreasonable demands on Police time.

6 AMENDMENT VARIATION

- 6.1 The parties agree that these understandings may be amended or varied by mutual agreement between partners. Such variations should be raised and

addressed through the National Operations Manager for the Police and the Deputy Director of Mental Health for the Ministry of Health.

Signed by:

On behalf of the New Zealand Police

Signed by:

On behalf of the Ministry of Health

