



## LEGAL COERCION FACT SHEETS

2016

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## Legal Coercion Factsheet 1

### The UN Convention on the Rights of Persons with Disabilities in New Zealand

#### About the Convention

The Convention on the Rights of Persons with Disabilities (CRPD) (1) was passed by the United Nations (UN) General Assembly in 2006. The CRPD clarifies the application of the rights set out in other United Nation human rights treaties to people with disabilities.

The CRPD adopted the social model of disability and has a human rights orientation. The preamble to the CRPD emphasised the need to alter societal attitudes. The CRPD reported that -

- (a) disability results from interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others and
- (b) persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world.

This preamble reflects the social model of disability, that is disability is not attributable to the individual, rather “disability” is the disadvantage that results from barriers created by the social, political and physical environment. This wider context inhibits the ability of persons who have long-term physical, mental, intellectual or sensory impairments to exercise their human rights. Consequently, the fundamental aims of the CRPD are to ensure that people with impairments are not discriminated against and that they enjoy the same rights and freedoms as people without impairments.

Countries that ratify the CRPD are obligated under international law to implement it. This implementation is demonstrated through, for example, the development of policies and laws to secure the rights recognised in the CRPD. This may require removal or revision of law and regulations, customs and practices that are discriminatory. The CRPD establishes a process to monitor how well signatories have implemented the CRPD.

#### New Zealand and the CRPD

New Zealand signed the CRPD on 30 March 2007 and ratified it on 25 September 2008, one of the first countries in the world to do so. Officials then checked the compliance of New Zealand legislation with the CRPD (2). While they determined that there was no problem with the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) itself, provisions in other legislation that prevented people under the Mental Health Act from performing certain public or fiduciary roles were found to be non-compliant and were repealed.

In New Zealand, international treaties such as the CRPD do not automatically become part of domestic law and are not directly enforceable through the courts, as they are in some other countries. However, by ratifying the CRPD New Zealand does now have an obligation under international law to implement it. Part of this obligation includes the requirement that New Zealand monitor and report on its progress with implementation including by way of at least one independent mechanism and the full participation of civil society, and in particular people with disabilities in the monitoring process both domestically and with the UN.

New Zealand has not yet signed up to the Optional Protocol to the CRPD. If New Zealand did the UN Committee on the Rights of Persons with Disabilities (the independent CRPD monitoring committee) would receive and consider individual complaints from New Zealand regarding violations of CRPD.

The UN Convention on the Rights of Persons with Disabilities is potentially the most transformative legal initiative affecting persons with disabilities. The Asia Pacific region is being regarded as behind the international community because of the absence of a regional court or commission such as exists in the European Court of Human Rights, The Inter-American Commission on Human Rights and The African Commission on Human Rights. (3)

### The CRPD and Compulsory Treatment

The jurisprudence being established by the UN Committee on the Rights of Persons with Disabilities seems unequivocal that the CRPD **marks a radical shift** in the lawful grounds for deprivation of liberty under international human rights law (4). More specifically, deprivation of liberty based on the existence of disability, including mental, is not compliant with the CRPD.

The articles of particular significance to service users and most pertinent in terms of this jurisprudence are: **Article 12 (Equal recognition before the law)** – the right to enjoy legal capacity on an equal basis with others in all aspects of life, including the right to give consent for medical treatment; and **Article 14 (Liberty and security of the person)** – the right to be free from involuntary detention in a mental health facility and not to be forced to undergo mental health treatment.

In light of this the Committee have advised a number of countries that they need to revise or repeal all legislation that authorises medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders (5).

*States parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; must ensure that accurate and accessible information is provided about service options and that non-medical approaches are made available; and must provide access to independent support. States parties have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The Committee recommends that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned (6).*

On the basis of the reports received to date the UN Committee on the Rights of Persons with Disabilities have identified that there seems to be a general failure to understand (5, 6):

- That unlawful detention and /or treatment includes situations where the deprivation of liberty is grounded in the combination between a mental disability AND other elements such as dangerousness, or the need for care and treatment (as is the case with the New Zealand Mental Health Act)
- The obligation to replace substitute decision-making regimes (as is the case with the New Zealand Mental Health Act) with supported decision-making regimes.

A consequence of the CRPD is a developing body of literature critiquing separate mental health legislation and advocating generic legislation adopting a single capacity based standard across the entire health sector for treatment without consent. The intention of such a change would support the autonomy of the individual to take decisions about treatment and replace the *parens patriae* doctrine, which enables the state to make decisions on behalf of an individual who is deemed mentally incompetent to make the decision on her or his own behalf.

### New Zealand – Monitoring and Reporting

In its first report to the Committee (8) New Zealand reported that there is no civil detention of people on the basis of disability as the trigger for detention under the Mental Health Act is not disability but the risk of harm to self or others (when in fact it is both). Since that time the Independent Monitoring Mechanism (IMM) (9) and New Zealand Disabled Person's Organisations (DPOs) (10) have recommended that the Government urgently review and change the Mental Health Act to ensure full compliance with the CRPD.

In response to the New Zealand Government, IMM and DPO reports, the UN Committee on the Rights of Persons with Disabilities reported and recommended that:

- New Zealand take immediate steps to revise the relevant laws and replace substituted decision-making with supported decision-making.... including with respect to the individual's right, in his or her own capacity, to give and withdraw informed consent, in particular for medical treatment (Article 12)
- It is concerned that the Mental Health (Compulsory Assessment and Treatment) Act 1992 has been criticised for its lack of human rights principles (Article 14)
- New Zealand take all the immediate necessary legislative, administrative and judicial measures to ensure that no one is detained against their will in any medical facility on the basis of actual or perceived disability (Article 14)
- New Zealand ensure that all mental health services are provided on the basis of the free and informed consent of the person concerned, in accordance with the Convention (Article 14)
- The Mental Health (Compulsory Assessment and Treatment) Act 1992 be amended to comply with the Convention (Article 14) (11).

The Government's response (12) – to reiterate that in New Zealand, no-one is allowed to be detained against their will in any medical facility on the basis of disability alone – shows a lack of appreciation for the emerging jurisprudence and an indifference to the mandate and radical shift required by the CRPD. The UN Committee on the Rights of Persons with Disabilities have advised

that, as a civil and political right, the rights provided for in Article 12 apply at the moment of ratification and are subject to immediate realisation. Hence, review and reform of the Mental Health Act is urgently needed in for New Zealand to fulfil their international legal obligations of being compliant with the CRPD and should be prioritised under the Disability Action Plan 2014-2018.

Although New Zealand was recognised as being a leader in negotiations on the Convention it has been noted that its international presence and influence in this area seems to have declined. This is particularly evident because New Zealand has not ratified the Optional Protocol to the CRPD while many countries with similar legal systems have, including Australia (10). This is despite entreaties for the Government to do so from the Independent Monitoring Mechanism, Disabled Person's Organisations, and the Committee on the Rights of Persons with Disabilities (8-10). In June 2015 the Government communicated that they are beginning the domestic treaty examination process with a view to acceding to the Optional Protocol (12). In the meantime, it is arguable that individual complaints could be taken in respect of the equivalent provisions under the International Covenant on Civil and Political Rights.

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## Legal Coercion Factsheet 2

### Rates of Compulsory Assessment and Treatment in New Zealand

#### About the Mental Health (Compulsory Assessment and Treatment) Act 1992

In 1954, 87.9 people per 100,000 population were committed patients of psychiatric hospitals. By 1969, the rate of such committal had dropped to 70.1 per 100,000 population (1). Between 1969 and 1992 the numbers continued to decline, and by the mid-1980s approximately half of those subject to legal coercion under the 1969 Act were actually receiving compulsory treatment in the community, by means of the so-called trial leave provisions (2).

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) replaced the Mental Health Act 1969, the purpose being 'to redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder'. One of the most significant changes that the 1992 legislation ushered in, both nationally and internationally, was explicitly the authorisation of compulsory community treatment orders (CTOs) explicitly.

The criteria for compulsory assessment and treatment under the 1992 Act are that the person has a 'mental disorder' (whether of a continuous or an intermittent nature) of such a degree that it poses a 'serious danger' to the health or safety of self or others or 'seriously diminishes capacity' for self-care. The first assessment and treatment period is for no longer than five days. It can then be extended for a second period of up to a further 14 days. These initial stages are most often conducted in an inpatient setting. If, at any time during the first period or second period, the clinician considers that the "patient"

is not mentally disordered and is therefore fit to be released from compulsory status, he or she must be immediately discharged. If, at the end of the second period, the clinician considers the patient is not fit to be released from compulsory status an application for a compulsory treatment order must be made to the Court. On an application for a compulsory treatment order, the court shall determine whether or not the patient is mentally disordered. If the court considers that the patient is not mentally disordered, it shall order that the patient be released from compulsory status forthwith. If the court considers that the patient is mentally disordered, it shall determine whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory treatment order. Every compulsory treatment order shall be either a community treatment order or an inpatient order. Both require that the person accepts the imposed treatment for a period of up to six months. At the end of the six month period the clinician may apply to the court for an extension of the order for a further period of 6 months. After two consecutive six month periods the next compulsory treatment order issued by the Court has effect indefinitely.

Since the introduction of the 1992 Act the overall rate of legal coercion in New Zealand has increased to an average of 103 people per 100,000 on any given day. Of these 85 per 100,000 (82.5%) are subject to community treatment orders, 14 per 100,000 (13.6%) are subject to inpatient

treatment orders, and 4 per 100,000 (3.9%) are subject to inpatient leave orders (3). As a point of comparison the total rate of legal coercion in England has gone from 28.7 people per 100,000 in 1984 (4) to 43.7 people per 100,000 in 2014 (5).

Of those 33.7 per 100,000 (77%) are subject to detention and 10 per 100,000 (23%) are subject to community treatment orders, with the latter having been introduced to the UK in 2007.

### Compulsory Assessment and Treatment in New Zealand 2005-2014

Since 2006 the Office of the Director of Mental Health has produced an annual report (1, 3, 6-13), which among other things, summarises activities under the MHA. The most recent report is based on 2014 activities, and together with consideration of previous reports, this allows for comparison over time nationally, as well as within and between District Health Boards (DHBs).

In 2014, 9280 people were subject to the Mental Health Act in some manner (1).

**Table 1. Compulsory Assessment**

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Initial 5 day assessment (S 11)	11	10	10	10	10	11	11	10	10	12
Further 14 day assessment (S 13)	9	8	8	8	8	8	9	9	9	11
Application for CTO (S 14(4))	5	5	5	5	5	5	7	6	6	8

*Table 1: Average number of people per month required to undergo compulsory assessment per 100,000 population in New Zealand (1, 3, 6-13)*

**Table 2. Compulsory Treatment**

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Community Treatment Order (S 29)	60	58	61	63	61	77	85	77	80	85
Inpatient Treatment Order (S 30)	17	16	15	13	14	14	19	13	12	14
Inpatient Leave Order (S 31)	5	6	5	5	4	6	7	4	3	4

*Table 2: Average number of compulsory treatment orders on a given day per 100,000 population in New Zealand (1, 3, 6-13)*

**Table 3. Types of Compulsory Treatment Orders**

Year	Granted applications for orders	Compulsory community treatment orders (or extension)	Compulsory inpatient treatment orders (or extension)	Orders recorded as both compulsory community and inpatient treatment orders (or extension)	Type of order not recorded
2005	3682	1576	1439	92	575
2014	4616	2651	1781	78	106

*Table 3: Types of compulsory treatment orders made on granted applications - 2006 and 2014 (3)*

Rates of compulsory treatment by District Health Board (DHB) in 2014

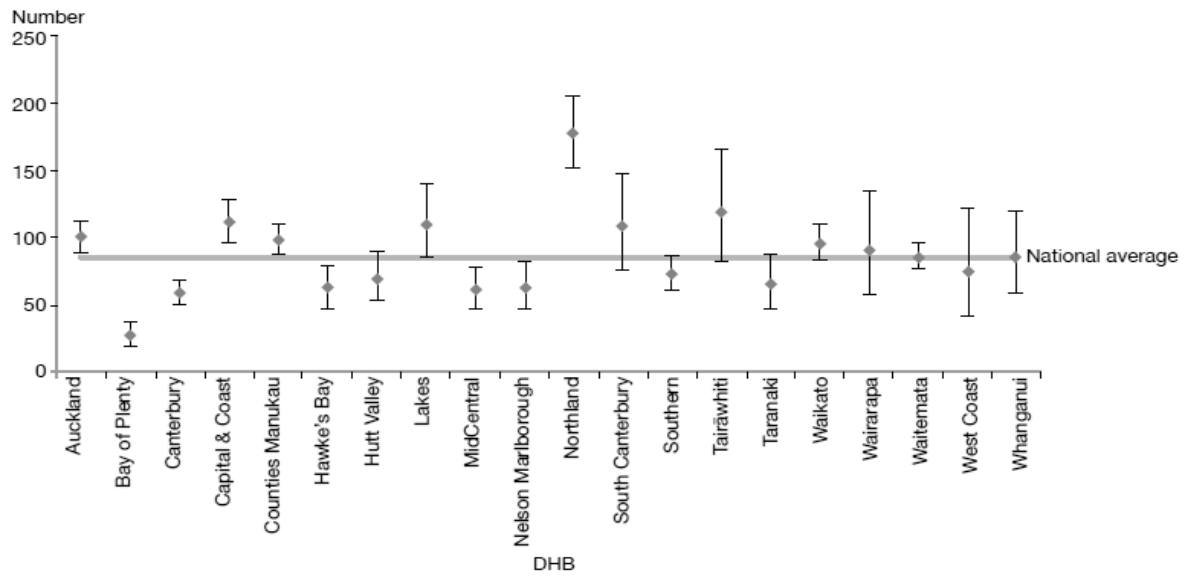


Figure 1: Average number of people District Health Board, 1 January to 31 December 2014 (3)

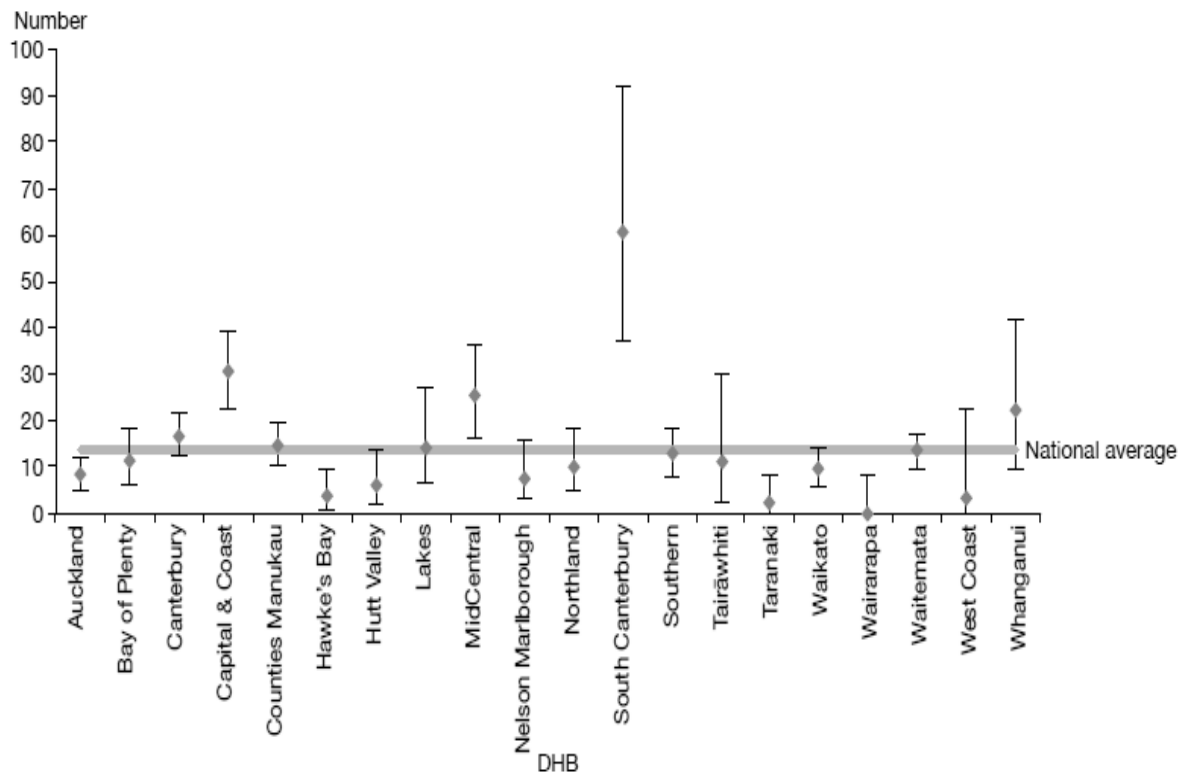


Figure 2: Average number of people per 100,000 on a given day subject to an inpatient treatment order (section 30 of the Mental Health Act), by District Health Board, 1 Jan to 31 December 2014 (3)

What this shows is that despite the national policy endorsement of the service philosophy of recovery (14), which explicitly prioritises individual autonomy, and the concerns associated with compulsory treatment from a human rights perspective (see Factsheet 1), since 2005 rates of assessment and treatment have increased both absolutely and proportionally to population growth (approximately 9% (population increase) versus 25% (increase in granted applications for compulsory treatment orders generally), 68% (increase in compulsory community treatment orders or extensions granted); and 24% (increase in compulsory inpatient treatment orders or extensions granted)).

Based on a population figure of 4,509,000 in 2014, 85 people per 100,000 under a community treatment order on any given day in 2014 equates to 3832 and yet the number of community treatment orders granted or extended in 2014 is reported as 2651. It is likely that much of the difference in these two numbers reflects the significant number of people that are now subject to indefinite compulsory treatment.

There is also notable variation between DHBs in rates of use of the Act. In 2014 the rates of use of community treatment orders (CTOs, section 29) ranged from 28 (Bay of Plenty DHB) -177 (Northland DHB) per 100,000 on any given day, a six-fold variation between the highest and lowest rates; and from 4 (Hawkes Bay DHB) - 61 (South Canterbury DHB) per 100,000 on any given day for compulsory inpatient treatment orders (section 30), a 15-fold variation (3)

In 2014 males were 1.5 times more likely to be subject to a compulsory treatment order (111 per 100,000) than females (72 per 100,000) (3). In terms of age, people aged 25–34 years were the most likely to be subject to a compulsory treatment order (196 per 100,000) and people over 65 years of age were the least likely (53 per 100,000) (3). In 2014 Māori were 3.5 times more likely to be subject to a community treatment order (section 29) than non-Māori (3). This was up from 2.9 in 2013 (6). For more information about the disparities faced by Māori in relation to the Mental Health Act, see Factsheet 5.

## Comparisons with Other Countries

The use of compulsory assessment and treatment in New Zealand is high by international comparison.

A recently published article compared the rate of use of CTOs in New Zealand with international prevalence rates (15). It found that whilst rates of use of CTOs are increasing internationally, New Zealand's CTO use (85 people per 100,000 population) is high by international comparisons, with New Zealand's rate being higher than every Australian region, with the exception of Victoria (99 per 100,000), and any of the other international comparator jurisdictions. New Zealand rates also show greater variability and more dramatic increases than any Australian or other jurisdiction. Of note is that those jurisdictions identified as having the lowest rates – Ontario (2 per 100,000), Saskatchewan (2 per 100,000) and Scotland (3 per 100,000 in 2005 and 15 per 100,000 in 2012) - all include impaired decision-making capacity or judgment as a criterion for non-consensual treatment; as compared with New Zealand where it has been estimated that roughly two-thirds of people under compulsory treatment in New Zealand would have the capacity to consent, or to refuse consent, to treatment (16). The more recent (2014/2015) rates from those comparator jurisdictions include England (5), Wales (17), and Scotland (18) where 5365 (10 per 100,000), 240 (8 per 100,000\*) and

910 (17 per 100,000) people were reported to be subject to Compulsory Treatment Orders respectively. There is a major difference between the mental health legislation governing England and Wales, and that of New Zealand, is that a CTO can only be applied to a person who has been detained in hospital and the relevant definition and criteria do not include mental disorder of an intermittent nature.

\* Calculated based on reported population figures.

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## Legal Coercion Factsheet 3

### Seclusion and Restraint in Mental Health Services in New Zealand

#### Definitions and Standards for Use

The New Zealand Health and Disability General Standard (1) defines restraint as ‘the use of any intervention by a service provider that limits a consumer’s freedom of movement’, including personal restraint (the use of one’s own body to intentionally limit the movement of a service user); physical restraint (the use of furniture, devices or equipment to limit movement; e.g. belts on chairs); and environmental restraint (restricting access to the environment; e.g. locked doors). The Restraint Minimisation Standard (2) also includes chemical restraint (defined as various medicines used, to ensure compliance and to render the person incapable of resistance, rather than for therapeutic purposes) and stipulates that restraint [including seclusion] is only to be used after all less restrictive interventions have been attempted and found to be inadequate. Positive approaches should be used at all times. Where reactive strategies become necessary, de-escalation should be used before restraint.

Seclusion, defined in the Restraint Minimisation Standard (2) as an event ‘where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit’, is authorised under section 71 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. The seclusion standard (in the Restraint Minimisation Standard) states that ‘seclusion should only be used to prevent violent behaviour compromising safety’. Seclusion ‘should be used for as short a time as possible and is best conceived as a safety mechanism rather than a therapeutic intervention or treatment ... Seclusion should not occur as part of a routine admission procedure or for punitive reasons’. (2)

The Restraint Minimisation Standard requires services to record and monitor all instances of restraint and seclusion. It also requires that organisations subject their use to rigorous internal and external review by consumers, family/whanau, professionals, and relevant professional bodies (2).

#### How Service Users Experience Restraint and Seclusion

Seclusion and restraint are often experienced by service users as punitive rather than therapeutic. Evidence suggests that seclusion and restraint pose significant risks to service users, including death, re-traumatisation, loss of dignity and other psychological harm (3). It can also be a traumatic experience for staff.

#### Rates of Seclusion and Restraint within New Zealand Mental Health Services

National data on the extent of use of personal, physical and environmental restraint in mental health services is not publically available but data on rates of seclusion have been published since 2007. All District Health Boards (DHBs) except for Wairarapa (which has no mental health inpatient service) use seclusion (4). Efforts to progressively decrease and limit the use of seclusion and restraint began in 2009 (2) and since 2012, reduction and elimination has been a priority action of Rising to the Challenge (New Zealand’s Mental Health and Addiction plan) (5). The reported figures (4) show that between 2009 and 2014 the total number of people who experienced seclusion while receiving

mental health treatment in an inpatient service decreased by 32 percent and the total number of hours spent in seclusion decreased by 55 percent. However, the people who are secluded are often secluded more than once (on average 2.4 times in 2014). Therefore, the number of seclusion events in adult inpatient services (1804 in 2014) is higher than the number of people secluded. People aged 20–29 years are more likely to be secluded than those in any other age group, and a total of 111 young people (under 19 years) were secluded during the 2014 year, in 339 seclusion events. The frequency of time spent in seclusion varied considerably with 14% of seclusion events lasting longer than 48 hours.

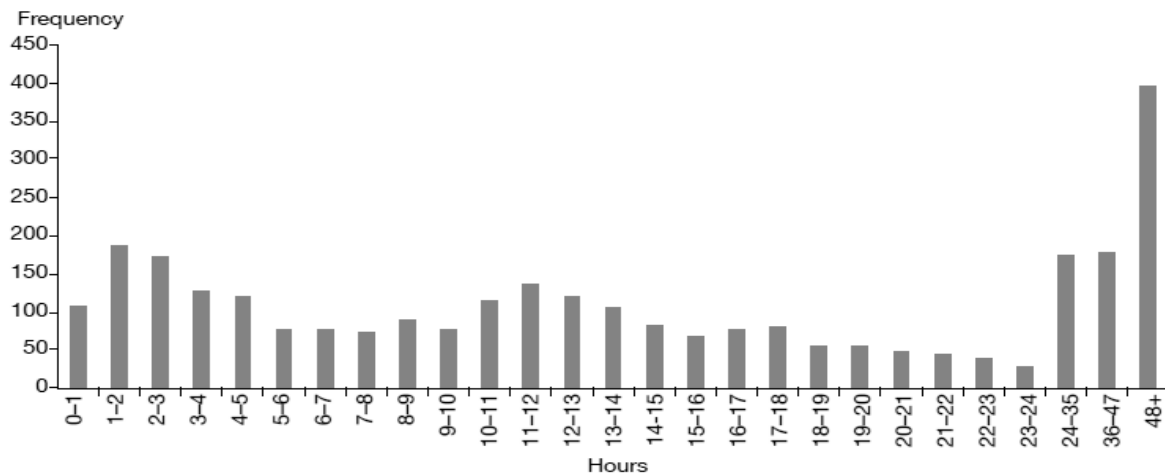


Figure 1: Distribution of seclusion events in all mental health inpatient services (adult, forensic, ID and youth), by duration of event, 1 January to 31 December 2014

The number of people secluded and number of seclusion events also vary widely across DHBs with some being 2 or 3 times higher than the national averages.

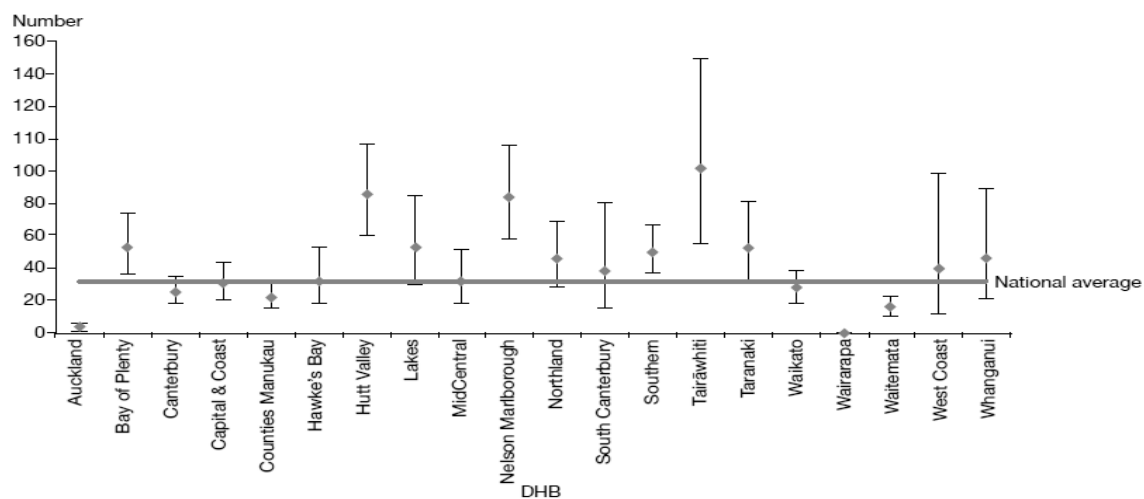


Figure 2: Number of people secluded in adult inpatient services per 100,000, by DHB, 1 January to 31 December 2014

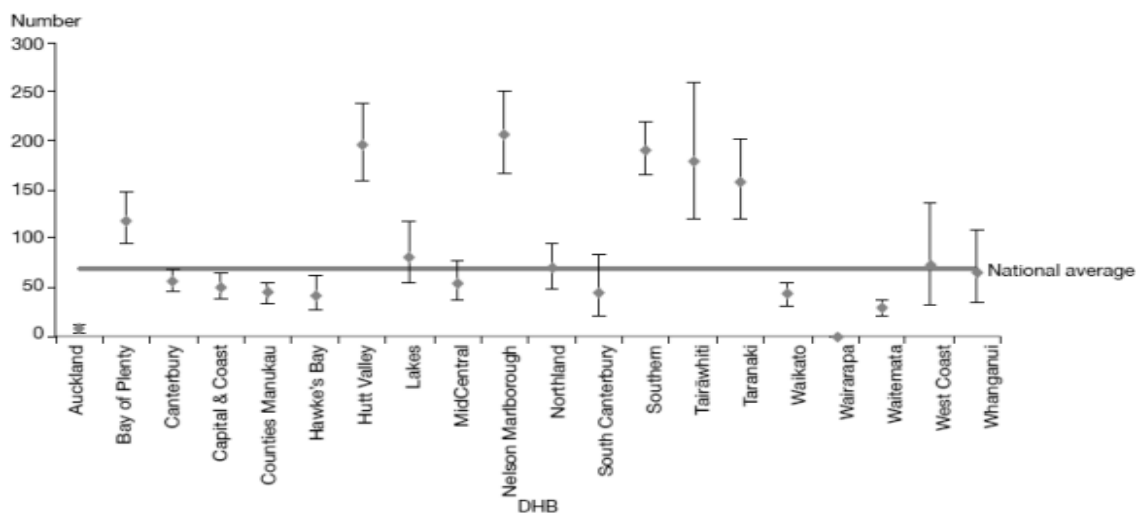


Figure 3: Number of seclusion events in adult inpatient services per 100,000, by DHB, 1 January to 31 December 2014

In 2014, Māori were secluded almost four times more than non-Maori, (67.9 people per 100,000 as compared with 18 per 100,000 for non-Māori).

There are also extreme examples that have come to light. The Office of the Ombudsman reported a case of potential cruel and inhumane treatment in a mental health patient who had been in virtually constant restraint and seclusion for six years (6). The Director of Mental Health responded that he was ordering an urgent report (7). In its subsequent annual report, the Office of the Ombudsman noted that it had taken the ‘unreasonably long period’ of 13 months for the patient to be moved to a more suitable facility (8).

### Seclusion and Human Rights

Whilst acknowledging the reduction in the use of seclusion, several United Nations bodies have identified that the current situation in relation to New Zealand’s use of seclusion is contrary to New Zealand’s international human rights obligations under a number of Conventions.

The Special Rapporteur on torture declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions, the imposition of solitary confinement, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment; both prolonged seclusion and restraint may constitute torture and ill-treatment (9). He advised an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological disabilities, should apply in all places of deprivation of liberty, including in psychiatric institutions.

In response to the sixth periodic report of New Zealand on the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Committee on Torture communicated (10):

### Excessive use of seclusion in mental health facilities

*While welcoming the adoption of plans aimed at eliminating the practice of seclusion], the Committee is concerned at information received on the persistent use of seclusion in Mental Health facilities for purposes of punishment, discipline and protection, as well as for health-related reasons. The Committee further notes that a significant number of victims have been secluded for more than 48 hours and that Māori are more likely to be secluded. The Committee is concerned at information that the State Party is continuing to include in new psychiatric facilities cells specifically designed for solitary confinement...The Committee also notes the lack of relevant statistical information (art. 16, 11 and 14).*

As a result, the Committee recommended that New Zealand should:

- (a) Limit the use of solitary confinement and seclusion as a measure of last resort, for as short a time as possible, under strict supervision and with the possibility of judicial review;
- (b) Prohibit the use of solitary confinement and seclusion for juveniles, persons with intellectual or psychosocial disabilities, pregnant women, women with infants and breastfeeding mothers, in prison and in all health-care institutions, both public and private;
- (c) Conduct prompt, impartial and thorough investigations into all allegations of ill-treatment in prisons and health-care institutions, both public and private;
- (d) Prosecute persons suspected of ill-treatment and, if found guilty, ensure that they are punished according to the gravity of their acts; and provide effective remedies and redress to the victims;
- (e) Compile and regularly publish comprehensive disaggregated data on the use of solitary confinement and seclusion.

Of note is that New Zealand has accepted that the Committee on Torture can receive and consider individual complaints about violations of the provisions of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment by New Zealand (11).

Similarly, in response to its first report on implementation of the Convention of the Rights of Persons with Disabilities, the Committee (12) noted in relation to Article 14 - **Liberty and security of the person** - that New Zealand's position of continuing to allow the use of seclusion and restraints in psychiatric hospitals is not satisfactory. They recommended immediate steps be taken to eliminate the use of seclusion and restraints in medical facilities. Despite this, the Government continues to justify the practice as is reflected through their response to the Concluding Observations of UN Committee on the Rights of Persons with Disabilities: 'Seclusion and restraint are sometimes needed in mental health facilities when a patient poses a serious risk to themselves and/or others, and other interventions have proved ineffective' (13).

Finally, based on their country visit in 2014, the United Nations Working Group on Arbitrary Detention expressed its concern relating to the widespread practice of seclusion in psychiatric units and while recognising the Government's achievement in reducing the incidents of seclusion since 2009, it urged authorities to eliminate this practice (14).

In terms of domestic law, whilst the Bill of Rights Act 1990 is not supreme law, which means that no other enactment can be impliedly repealed or revoked, or to be found in any way invalid or ineffective, or not applied, by reason only that the provision is inconsistent with any provision of the Bill of Rights, the rights and freedoms enshrined may be subject only to such reasonable limits prescribed by law as can be demonstrably justifiable in a free and democratic society. Given the UN position, it is at least arguable that the current high use of seclusion by New Zealand is limiting the right not to be subjected to torture or cruel treatment (section 9) in a way that is not demonstrably justifiable in a free and democratic society. In that context the high rates of seclusion coupled with the experience and testimonies of recipients of the practice are at odds with the Bill of Rights and difficult or impossible to justify.

### Efforts to Reduce and Eliminate Seclusion and Restraint

Te Pou o Te Whakaaro Nui (National Workforce Centre for Mental Health, Addiction and Disability) supports the national direction set by the Ministry of Health for seclusion reduction by using evidence-based information, such as the 'Six Core Strategies' of the National Technical Assistance Centre:

1. Organisational leaders are committed to supporting and resourcing seclusion and restraint reduction and elimination.
2. Data on seclusion and restraint rates, practices and experiences is used to inform practice.
3. The workforce is competent in recovery, trauma informed care and in creating a calm milieu.
4. Seclusion and restraint reduction tools are in place such as individual safety assessment and planning tools, and sensory modulation approaches.
5. Service users and families are involved in reduction and elimination in a variety of roles including advisory, training, evaluation and debriefing.
6. Every seclusion and restraint event is followed by debriefing, which informs future practice, with managers, staff and service users (15).

Particular strategies aimed at reducing the disparately high rates of Māori seclusion include:

- Use of culturally appropriate physical space
- Use of traditional processes of engagement such as powhiri, karakia, mihimihi, and kai
- The presence of Māori staff
- Appropriate cultural assessment
- The fostering of tino rangatiratanga for tāngata whaiora and their whanau
- Cultural competency for all staff (16).

There are currently no mechanisms for consistently collecting data about the extent to which these strategies are being implemented or information about the challenges of implementation and devised local solutions.

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## Legal Coercion Factsheet 4

### Legal Protections under New Zealand's Mental Health Act

One of the explicit purposes of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) was to *'define the rights of such persons and to provide better protection for those rights'*. This includes people and procedures responsible for the review and investigation at both the individual and systemic levels.

#### Rights under the Mental Health Act

In addition to the rights of review (as detailed below), under Part 6 of the MHA stipulates, every person subject to the Act in any manner has the right to:

- Information.
- Respect for cultural identity.
- An interpreter.
- Appropriate treatment.
- Be informed about treatment
- Refuse video recording
- Independent psychiatric advice.
- Legal advice.
- Company.
- Have visitors and make telephone calls
- Send and receive mail
- Complain about breach of rights.

#### Protections: People and Procedures

##### Representation at hearings and reviews: lawyers and legal aid

People under the MHA have the right to a lawyer to represent them, and legal aid to cover the cost of that representation, at hearings of applications for compulsory treatment orders (CTOs) and reviews of compulsory assessment orders before the Family and District Courts, and reviews of CTOs before the Mental Health Review Tribunal (MHRT).

##### Reviews of Compulsory Assessment Orders: Family/District Court

Under section 16 of the MHA, people can apply to the Family Court or District Court for a review of their compulsory assessment status at any time during the initial 19-day period. Following application, the Judge must hold the hearing and consult with the professionals involved as soon as practicable. If the Judge believes that the person is fit to be released from compulsory status they must be released immediately. In 2014 approximately 1152 applications were considered under section 16 of MHA (1). Of this total, an order for release of the person from compulsory status was issued in 32 cases (2.8 percent of total applications, 5 percent of the applications that proceeded to hearings).

### Hearings of applications for Compulsory Treatment Orders: Family/District Court

In 2014, there were 5236 applications for CTOs or extensions, of which 4616 (88%) were granted; 573 (11%) were withdrawn, lapsed or discontinued; and 47 (1%) were dismissed or struck out (1).

### Watchdogs of patients' rights: District Inspectors

District Inspectors (DIs) are lawyers appointed by the Minister of Health under the MHA. Their functions and powers include:

- (i) providing process information to individuals and their families, including the rights of complaint and review;
- (ii) checking documentation;
- (iii) visiting individuals subject to compulsory assessment and treatment;
- (iv) considering whether a review by a Judge under section 16 is warranted;
- (v) visiting and inspecting any hospital or service in the DI's locality, including both inpatient or outpatient facilities;
- (vi) complaint investigation, resolution and reporting;
- (vii) conducting inquiries (where there is clear evidence that outstanding issues are not being addressed by the mental health service) (2).

DIs also have a role in ensuring access to the right to a lawyer and legal aid. The guidelines for Dis stipulate that when an application for a compulsory treatment order is made the District Inspector should ensure that a system is in place to provide the patient with a lawyer, and that the name and phone number of the rostered lawyer for that week is available to the patient.

One study on how DIs work in practice (3) identified a number of challenges this role entails. Drawing on the findings from 20 semi-structured interviews with DIs through 2011, the study found that *"at times, patients, their families and clinical staff lacked necessary information and some DIs felt that this led to complaints going unheard. This was particularly relevant in the community, where patients were not visited as frequently by DIs, even though the MHA prioritises the community as the site for compulsory assessment and treatment"* (p. 144). It was also found that most complaints were addressed through informal means. Inquiries were rare, with only a small number of DIs having completed one, and the study being unable to ascertain why that is. In fact, since 2003 there have only been 17 inquiries in total, none completed during 2013 and none reported for 2014 (1,4).

### Reviews of Compulsory Treatment Orders: Mental Health Review Tribunal

People can apply to have their compulsory treatment status reviewed by the Mental Health Review Tribunal (MHRT) (an independent body comprising three members, one of whom must be a lawyer and one a psychiatrist. By convention the third member is a community member. In addition, if a person or other complainant is not satisfied with the outcome of the complaint of a breach of rights to the DI, he or she may refer the case to the MHRT for further investigation. The DI has a role in assisting people to lodge an application to the MHRT and there may be a correlation between DI practices and number of applications. To the year ended 30 June 2015, the Tribunal received 145 applications for review of a CTO, of which 20 (14%) were deemed ineligible, 54 (37%) were

withdrawn, 13 (9%) were held over to the subsequent year and 58 (40%) were heard during the report year (5). Of those, and the 4 held over from the previous year that were also heard, 5 (8%) were determined fit to be released from compulsory status and 57 (92%) not fit to be released from compulsory status. This rate is slightly higher than the average over the past 10 years (6%).

Based on a descriptive statistical overview of MHRT outcomes from 1992 to 2011 Thom (6) concluded that it is clear the MHRT only reviews the condition of a minority of patients being treated under the MHA. Of that minority the success rates are low compared with some international jurisdictions (e.g. 31% in Canada and 34% in the United Kingdom), while at the same time withdrawals are high, which may be because the application itself triggers a response from the Responsible Clinician.

Applicants in the community are particularly underrepresented, which is of concern in the context of rising use of community treatment orders (6). Thom notes that this might be a result of people who are subject to community treatment orders not being visited as frequently by DIs as inpatients are (3), meaning that they are not as routinely informed about their right to apply to the MHRT. The DI role is more based on the prevailing earlier models of “inspection” of the asylum.

A review of 80 MHRT decisions between 1994 and 2012 identified the implicit factors, not found in the legislation, such as ‘insight’ and ‘compliance with medication’, which seem to influence discharge decisions (7).

#### Judicial inquiry into person detained in hospital: High Court

People detained in hospital can apply to the High Court for a judicial inquiry into the legality of their detention under the MHA. This is sometimes called a writ of habeas corpus. This is rarely used and in *Sestan v DAMHS* [2007 1 NZLR 767, 784] Robertson J emphasised that although a person is entitled to seek a writ of habeas corpus “*the mechanisms contained within the MH(CAT) Act will, in normal circumstances, be much more efficacious and appropriate*”.

#### Criticisms of Legal Protections

A recent systematic review of the empirical literature on the decision-making of mental health review tribunals (from the UK, Australia, New Zealand, Canada, and Ireland) identified 11 prevailing themes that largely relate to the shortfalls and procedural unfairness of current tribunal systems:

- Extra-legal factors prominent (e.g. factors outside of strict laws governing Tribunals were often crucial to Tribunal member’s decision-making)
- The health context dominates (e.g. the decision-making of Tribunals privileges medical opinions)
- The role of the psychiatric Tribunal member (e.g. ambiguity around the role, stemming from their acting both as expert witness and decision-maker)
- Clinicians inadequately prepared (e.g. reporting from medical witnesses is often incomplete, of low quality, or missing altogether)
- ‘Dangerousness’ and ‘risk’ most important
- Going beyond their jurisdiction (e.g. extending their decision-making beyond the statutory boundaries of the Tribunals)
- The marginalisation of lay members (e.g. alliances between legal and medical professionals may lead to the marginalisation of lay members’ voices)

- Experiences of powerlessness (e.g. applicants experiencing communication problems, feeling confused, distressed, anxious, powerless and dissatisfied with Tribunal procedures)
- Enhancing therapeutic outcomes (e.g. Tribunals' efforts to encourage the communication and collaboration between the Tribunal applicants' and members of the multidisciplinary care team)
- Inadequate legal representation (e.g. frequent absence of legal representation, lawyers lack of understanding of mental health law and/or not vigorously advocating on applicants' behalf, applicants' not being aware of their rights and the kinds of support services available and where to obtain assistance within the Tribunal system)
- The future of the Tribunal system (e.g. the need for improvement to ensure a more efficient and just Tribunal system) (8).

Studies of mental health review tribunals have found that reviews of statutory criteria can unavoidably lead to wider discussion of the applicant's current and future treatment plans(9). Although it is outside the jurisdiction of New Zealand's MHRT to make comments on treatment plans, Thom, Black and Panther (10) suggested discussions on medication regimes, possibilities for living independently, and access to help with trauma or addiction seemed to directly address the needs of applications and contribute to their perceptions of truly being heard. They further suggested the notion of MHRT being able to independently review treatment plans is worthy of further consideration.

United Nation review bodies have also raised concerns regarding MHA review procedures. Based on their visit to New Zealand, the United Nations Working Group on Arbitrary Detention reported that they were concerned that *"the legislative framework is not effectively implemented to ensure that arbitrary deprivation of liberty does not occur. In practice, compulsory treatment orders are largely clinical decisions, and it is difficult to effectively challenge such orders. Although the Mental Health Act guarantees the right to legal advice for all patients, persons undergoing compulsory assessments are often unrepresented in practice, as they do not have access to legal aid. The Family Court, which makes compulsory treatment orders, is not a specialist court in mental health and seems to have the tendency to heavily rely on medical reports by merely one clinician and one other medical professional, who, in most cases, is a registered nurse"* (11).

The Working Group's observations are based on meetings with various executive and judicial authorities, representatives of the New Zealand Human Rights Commission, members of the New Zealand Bar, practising solicitors, academics, and representatives of civil society organizations; visits to places where people are deprived of their liberty and interviews with detainees. Their incorrect perception that people subject to the Mental Health Act do not have access to legal aid could perhaps reflect that this is not generally and/or commonly understood. The Committee on the Rights of Persons with Disabilities has stressed the necessity to implement monitoring and review mechanisms in relation to persons with disabilities deprived of their liberty whilst also noting that this should not entail acceptance of the practice (12).

The United Nations Committee against Torture noted the lack of relevant statistical information in relation to the excessive use of seclusion in New Zealand mental health facilities (13).

One of the most important criteria for evaluation of compulsory treatment legislation from a human rights perspective is the availability and accessibility of regular, independent review processes (14). At the individual level they provide a more robust safeguard against inappropriate detention than appeal processes, as they are not initiated by the patient, who may be subject to undue influence or lack of resources. This contrasts with the MHRT process which relies on a person under the Act being aware of the MHRT and how to lodge an application. The allowance for orders to become 'indefinite' under the MHA, with no requirement for regular independent review of a person's compulsory status before a court or tribunal, is therefore highly problematic. Given the Act's age there is the possibility that some people have been subject to compulsory treatment for over twenty years without an independent review.

Some argue that the legal protections and the monitoring of the Mental Health Act should be funded separately from the institution that funds the implementation of the Act to avoid a conflict of interest (4). In New Zealand the District Inspectors and the Mental Health Review Tribunal are funded by the Ministry of Health, the body also responsible for administering the implementation of the Act. At the systemic level that same body produces reports on activities under the Act with no independent monitoring mechanism. In contrast, Australia, England, Scotland, Ireland, and Canada all have Commissions that have some form of independent monitoring function and/or initiative to reduce the use of involuntary treatment. Notably most of them refer to human rights imperatives as the justification for doing so (15). Whilst the increase in coercion is common to many countries, there is an apparent difference in response between New Zealand and countries with independent monitoring mechanisms, particularly in terms of the level of critical analysis in monitoring the situation at the systemic level.

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## Legal Coercion Factsheet 5

### Maori Mental Health

#### Maori in Aotearoa New Zealand

Maori are the Indigenous people of Aotearoa New Zealand and make up approximately 15% of the population. In 2015, 1 in 3 Māori were under 15 years of age, while only 1 in 17 was aged 65 years and over (1).

Māori are over-represented in all negative health and social statistics (2). The social determinants of good mental health are linked to education, economic status, housing and employment, all areas in which Māori are disadvantaged (3). These facts cannot be fully understood without a contemporaneous recognition of the effects of the post-colonial context of Māori today, for example the land wars and a systematic legal framework leading to the loss of Māori land, language and identity. (For more information see, for example Durie (4), Jackson (5), Kingi (6), Robson and Harris (7), and Rochford (8).)

#### Maori Mental Health Today

For reasons associated with the facts touched on above, Māori have almost twice the rate of diagnosed serious mental illness compared to non-Māori, and are similarly over-represented in complex and co-existing conditions (9-11). Research in the last decade has found that Māori were more likely than non-Māori to be admitted to inpatient units with hallucinations and/or aggression, and less likely to present with depression and/or episodes of self-harm (12). Māori are more likely to present to services late and in crisis, often via Mental Health Act and/or the police, and are more likely to be readmitted (13-15).

In 2014 Māori were secluded almost four times more than non-Māori, with young Māori men and Māori women between the ages of 55-64 years have the highest rate of seclusion in absolute numbers (16). Maori were 3.5 times more likely to be subject to a community treatment order (section 29) than non-Māori (17).

Provisional figures from the Chief Coroner show that in the year to 30 June 2015, 130 Māori died by suicide (21.74 deaths per 100,000) (18). About one in every five New Zealanders who die by suicide is Māori.

#### Systemic issues with Māori mental health

Explanatory models for the high rates of Māori compulsion and seclusion have focused generally on markers of social deprivation, with the exception of Māori authors such as Durie, Kingi, Elder and Tapsell who identify the influence of race, cultural competence in practitioners, and colonisation as significant in the way mental health services assess, respond to and treat Māori.

There are currently no mechanisms for consistently collecting data about the extent and efficacy of the strategies to reduce restraint and seclusion for Māori, nor is there data about Māori service user and clinician experiences of using and adapting the strategies at a local level.

District Health Boards have been collecting Programme for the Integration of Mental Health Data since 2007, and although issues and solutions relating to Maori and the Mental Health Act have been



discussed among the District Health Boards there has been no universally accepted approach to date. The Ministry of Health has not published their own analysis of the data.

### Maori Solutions

There are many Māori psychiatrists, nurses and researchers generating papers and strategies aimed at addressing Māori mental health. A small example of these include a resource that supports a reduction in the use of restraint and seclusion for Māori (19), an analysis of the Mental Health Act in relation to Māori by psychiatrists Hinemoa Elder and Rees Tapsell (15), and a significant body of work by Professor Sir Mason Durie that has consistently promoted a Māori worldview (4, 20-24).

In general Maori health professionals are working alongside Māori service users and their whānau to adapt a health system that is based on a diagnostic medical model that, depending on the assessors' knowledge and experience, may or may not acknowledge and consider cultural explanations in their formulation and treatment. However, Māori health professionals who advocate strongly for cultural health reforms are often considered as radical. Loss of status, income, and even professional registration are realities that need to be taken into consideration.

Without significant reforms occur in the mental health, legal, research and education sectors Māori will continue to be disadvantaged by systems and practices that are predicated on mono-cultural , medical worldviews.

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## Legal Coercion Factsheet 6

### Fundamental Issues and Critical Questions

#### Lack of Evidence for Legal Coercion

In response to the General Comment on Article 12 of the CRPD (see fact sheet 1), a group of professors and/or clinicians of psychiatry have expressed the view that the interpretation of the Committee is contrary to previous intergovernmental human rights agreements, diverges from what is currently deemed best medical practice and threatens to undermine critical rights for persons with mental disabilities, including the enjoyment of the highest attainable standard of health, access to justice, the right to liberty, and the right to life (1). This is reflective of the doctrine of *parens patriae*.

In contrast the UN Committee on the Rights of Persons with Disabilities' view is that policies and legislative provisions that allow or perpetrate forced treatment are an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and

also the views of people using mental health systems who can experience deep emotional and psychological pain and trauma as a result of forced treatment (2).

In terms of the most common and extensively used form of legal coercion in New Zealand, compulsory community treatment - which is now in use in 70 jurisdictions internationally (3) a review of the most recent literature, pertinent to the arguments on the pro-side and the con-side, concluded that the scientific evidence that CTOs work is weak at best (4). The findings from the key studies upon which they base this conclusion include:

- A number of non-randomised studies that have provided negative and conflicting results and thus have not provided sufficient evidence to support community treatment orders.
- Three independent RCTs and a meta-analysis of their data that have shown no benefit of the CTO on the number of hospital admissions and other relevant outcomes (including service use, social functioning, mental state, homelessness, satisfaction with services or perceived coercion.).
- Patients on a CTO showing even less adherence to depot injections than those not on a CTO.

Similarly, based on an appraisal of the current literature on CTOs from the viewpoint of evidence-based medicine, it was concluded that the lack of evidence for patient benefit, particularly when combined with restrictions to personal liberty, is striking and needs to be taken seriously. If a strictly evidence-based approach is to be taken, then CTOs cannot continue to be used in their current form (3). Heun et al. argue that the time, money and resources spent on administration and report writing within the current CTO legislative framework would be better spent working with patients on developing more collaborative approaches to the ongoing management of their condition (4).

A recent Australian study found no difference on HoNOS outcomes when comparing people under CTOs and matched voluntary patients (5)

The lack of an evidence-base for CTOs is perhaps not surprising given that a recent review found that the published data is inadequate to conclusively evaluate whether long-term antipsychotic medication treatment results in better outcomes (6). In view of their finding the authors posed the question: *How is it that 60 years of research fails to produce evidence affirming the widespread clinical practice of maintenance antipsychotic treatment?* In the case of CTOs that widespread clinical practice often involves the compulsion of such treatment.

## Supported Decision Making

The UN Committee on the Rights of Persons with Disabilities' guidance is that:

- Denying legal capacity, including the right to give consent for medical treatment, on the basis of the diagnosis of an impairment (status approach), or where a person makes a decision that is considered to have negative consequences (outcome approach), or where a person's decision-making skills are considered to be deficient (functional approach) are all considered discriminatory in purpose or effect against persons with disabilities; and contrary to the Convention
- The Convention requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives
- A supported decision-making regime comprises various support options which give primacy to a person's will and preferences and respect human rights norms
- "Support" is a broad term that encompasses both informal and formal support arrangements, of varying types and intensity. For example, persons with disabilities may choose one or more trusted support persons to assist them in exercising their legal capacity for certain types of decisions, or may call on other forms of support, such as peer support, advocacy (including self-advocacy support), or assistance with communication... For many persons with disabilities, the ability to plan in advance is an important form of support, whereby they can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to others. All persons with disabilities have the right to engage in advance planning and should be given the opportunity to do so on an equal basis with others. States parties can provide various forms of advance planning mechanisms to accommodate various preferences, but all the options should be non-discriminatory. Support should be provided to a person, where desired, to complete an advance planning process. The point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity.
- Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the "best interpretation of will and preferences" must replace the "best interests" determinations (2).

## Critical Questions arising from Factsheets 1 – 5

What will influence the Government to review the Mental Health Act (MHA) in relation to its compliance with the Convention on the Rights of Persons with Disabilities (CRPD)?

What is likely to be the outcome of such a review?

The increase in the overall rate of legal coercion in NZ and high rate by international comparison is in contradiction to stated government policy and the service philosophy of recovery.

Why does this situation exist and what would influence change?

The use of CTOs varies notably between DHBs from 28 per 100,000 (BoP) on any given day to 177 per 100,000 (Northland) – a 6-fold variation. What is the explanation for these wide variations?

The use of compulsory inpatient treatment similarly varies widely from 4 per 100,000 (Hawkes Bay) on any given day to 61 (South Canterbury) – a 15-fold variation. Why are there such different approaches and practices in different places?

How is performance monitored and evaluated?

Males are 1.5 times more likely to be subject to CTOs than females and people aged 25-34 are most likely to be subject to a CTO. How many young men in NZ are on indefinite CTOs? Maori are 3.5 times more likely to be subject to a CTO than non-Maori. The rate went up from 2.9 times more likely in 2013 to 3.5 in 2014. Coercive practices are more likely to be used in areas where the Maori population is high – Northland, Tairāwhiti. Is this institutional racism arising from stereotyping and lack of cultural competence in the mental health service and other services?

How are these influences on decision making passed down through generations of consultants, registrars and other health professionals and how can this knowledge be changed?

Rates of usage of CTOs is increasing internationally but NZ's use is high by international comparisons and higher than every Australian region (except Victoria).

Is this justifiable or compatible with NZ's desire for progressive mental health policy and practice?

There is no therapeutic justification for the use of seclusion yet the practice persists in NZ, particularly in relation to young people 20-29. The variation in use between DHBs is notable with some being 2 & 3 times higher than the national average. The frequency of time spent in seclusion varies considerably and in 2014, 14% of seclusion events lasted longer than 24 hours.

Why does this practice continue; what would it take to eliminate?

Similarly, to CTO usage, Maori are almost 4 times more likely to be secluded than non-Maori. What lies behind these wide variation – is it related to funding limitations, attitudes and use of out of date practices, racist stereotyping and /or lack of cultural competence in the workforce

Should the use of seclusion be seen as an issue of quality and safety of care?

Do people know their rights and are the protections working?

Do individuals under the Act and their families have sufficient information, especially in the community where District Inspectors do not frequently visit?

Mental Health Review Tribunals only review the condition of a minority of people being treated under the MHA and of that minority success rates (of discharge) are low by international comparisons whilst at the same time withdrawals are high. Applicants in the community are

particularly underrepresented, which is of concern in the context of the rising use of Community Treatment orders. Does this situation sit comfortable alongside NZ's concern for human rights and the rights created by the Health and Disability Commissioner Act 1994?

From a human rights perspective, the availability and accessibility of regular independent review processes is one of the most important criteria for evaluation of compulsory treatment legislation and provides a more robust safeguard than appeal processes. The allowance for CTOs to become indefinite under the MHA with no requirement for regular review is therefore problematic. Is it possible that some people have been subject to compulsory treatment for over 20 years without review? On what basis could this be considered acceptable?

Australia, England, Scotland, Ireland and Canada have Commissions that have some form of independent monitoring function and /or initiative to reduce the need for involuntary treatment. How can NZ ensure monitoring at a systemic level and critical analysis of the key issues and questions highlighted in these factsheets?

## Conclusion

It is not an overstatement to suggest that most members of the public in NZ are unaware of the detailed operation of the mental health care system and in particular the extent of the use of legal coercion and compulsion. When attention becomes focussed, because of untoward incidents, there is a tendency for the public and media to err on the side of containment and compulsion. Despite past and continuing efforts to eliminate stigma and discrimination and respect rights there are still strong underlying currents of fear, blaming, othering and risk aversion.

The purpose of these factsheets and suggested questions is to stimulate discussion and debate about a critical issue in contemporary NZ policy and practices. On the face of it it relates to the practice and use of Mental Health Act, but at a deeper level it is to do with fundamental issues of human rights, equalities and adherence to the principles and intentions of the Treaty of Waitangi. Without more critical analysis and discussion there is a tendency for systemic complacency to result in no voice for change and no alternative vision.

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