New Zealand’s mental health legislation needs reform to avoid discrimination

Sarah E Gordon; Anthony O’Brien

Abstract

New Zealand’s Mental Health (Compulsory Assessment and Treatment) Act (the Act) is now over 20 years old. As has occurred historically our conceptualisation of humane treatment of people with mental illness has altered significantly over the period in which the Act has been in force. The emergence of the philosophy of recovery, and its subsequent policy endorsement, has seen a significant shift in mental health service delivery towards a greater emphasis on autonomy.

Human rights developments such as New Zealand’s ratification of the 2006 United Nations Convention on the Rights of Persons with Disabilities have resulted in compulsory treatment, where it is justified in whole or part by a person’s mental illness, now being considered antithetical to best practice, and discriminatory. However the number of people subject to the Act is increasing, especially in community settings, and it is questionable how effective the mechanisms for challenging compulsion are in practice. Moreover, monitoring of the situation at the systemic level lacks critical analysis.

Complacency, including no indication that review and reform of this now antiquated legislation is nigh, continues a pattern of old where the situation of people with experience of mental illness is largely ignored and neglected.

It is with interest that we read “Treatment of the Insane”, the reproduced article from 100 years ago in the New Zealand Medical Journal. In that article the authors attest to the deplorable state of the insane as a result of the carelessness and negligence of government in addressing facilities that were 25 years behind the times.

Many of the sentiments expressed relate to present-day analysis of New Zealand’s current mental health legislation, the Mental Health (Compulsory and Treatment) Act 1992 (The Act). New Zealand takes pride in its reputation for socially progressive legislation. However, some areas of the Act belie this self-belief.

In this paper we argue that although by some measures the Act can be said to be working well in certain important respects the Act is out of step with contemporary thinking about mental health and human rights. There are three strands to our argument. These are: increasing use of compulsion under the Act; the movement towards recovery philosophy in mental health; and recent developments in human rights under the 2006 United Nations Convention for the Rights of Persons with Disabilities (UNCRPD).

The UNCRPD has led to questioning of mental health legislation which is based, as in the New Zealand case, on mental illness (or disability) as one of its criteria for treatment without consent.
One consequence of the UNCRPD is a developing body of literature critiquing separate mental health legislation in favour of generic legislation based on capacity. We argue that it is time for New Zealand to respond to this international trend and consider adopting a single capacity based standard across the entire health sector for treatment without consent. In addition to legislative reform we recommend that rates of use of mental health legislation are closely and critically monitored and reported, with a view to reducing the overall use of compulsion in mental health care.

**Current legislation**

New Zealand mental legislation is based to a significant extent on the UK Mental Health Act of 1983 and was last revised 22 years ago. The 1992 Act strengthened procedural safeguards in committal processes, introduced a narrower, phenomenological, definition of mental disorder, and moved away from the previous “need for treatment” standard towards a standard based on the dual criteria of mental disorder and dangerousness. The Act also introduced community treatment orders, justifying this intrusion into individuals' autonomy on the grounds that it would facilitate the process of deinstitutionalisation and reduce the rate of involuntary hospitalisation.

A leading commentator on mental health legislation, has argued that all such legislation should be reviewed every 20 years or so. Although there appears currently to be little appetite for such a review, it is timely to reflect on how the Act has performed against its original aspirations, and how it stands in relation to contemporary treatment philosophy and international human rights developments that New Zealand has committed to since the legislation was enacted.

**How is the Act currently working?**

Since 2006 the Office of the Director of Mental Health has produced an annual report on key aspects of the functioning of the Act. Data from the annual reports (Table 1) show that since 2005 coercive uses of the Act have increased both absolutely and as a proportion of population numbers. The data suggest that the total number of people subject to both community and inpatient compulsory treatment is growing. An increase of 2 per 100,000 equates to 80 more individuals subject to the Act, and an increase of 25 equates to an additional 1000 individuals.

These numbers mean that New Zealand’s use of community treatment orders is amongst the highest in the world.
Table 1. Legislative activities under the Mental Health (Compulsory Assessment and Treatment) Act (1992) 2005–2011

<table>
<thead>
<tr>
<th>Legislative activities</th>
<th>2005</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessments that progress beyond the second assessment to an application for a</td>
<td>45%(^2)</td>
<td>67%</td>
</tr>
<tr>
<td>compulsory treatment order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applications for compulsory treatment orders or extension</td>
<td>4291</td>
<td>4755(^3)</td>
</tr>
<tr>
<td>Compulsory treatments orders granted</td>
<td>3671</td>
<td>4181(^1)</td>
</tr>
<tr>
<td></td>
<td>(85.6% of applications)</td>
<td>(87.9% of applications)</td>
</tr>
<tr>
<td>Average number subject to a compulsory treatment order:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community treatment (section 29)</td>
<td>60(^2)</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>(per 100,000 population)</td>
<td>(per 100,000 population)</td>
</tr>
<tr>
<td>Inpatient treatment (section 30)</td>
<td>17(^2)</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>(per 100,000 population)</td>
<td>(per 100,000 population)</td>
</tr>
<tr>
<td>Number of applications for review received by Family/District Court</td>
<td>950(^2)</td>
<td>1070</td>
</tr>
<tr>
<td>Number of applications for review heard by Family/District Court</td>
<td>640(^2)</td>
<td>592</td>
</tr>
<tr>
<td>Decisions of Family/District Court to release following section 16 inquiries</td>
<td>44(^2)</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>(4.6% of applications received/6.9% of applications heard)</td>
<td>(3.5% of applications received/6.3% of applications heard)</td>
</tr>
<tr>
<td>Number of applications for review received by Mental Health Review Tribunal</td>
<td>133(^2)</td>
<td>144</td>
</tr>
<tr>
<td>Number of applications for review heard by Mental Health Review Tribunal</td>
<td>78(^2)</td>
<td>72</td>
</tr>
<tr>
<td>Decisions of Mental Health Review Tribunal to release following section 79 inquiries</td>
<td>5(^2)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(3.8% of applications received/6.4% of applications heard)</td>
<td>(1.4 of applications received/2.9% of applications heard)</td>
</tr>
<tr>
<td></td>
<td>2007</td>
<td>2011</td>
</tr>
<tr>
<td>The number of seclusion events</td>
<td>3148(^3)</td>
<td>3410</td>
</tr>
<tr>
<td>The average number of seclusion events per patient secluded</td>
<td>2.75</td>
<td>3.5</td>
</tr>
</tbody>
</table>

1. Data source (except where indicated): Ministry of Health. Office of the Director of Mental Health: Annual Report 2011, Ministry of Health; 2012. The most recent (2013) report could not be used because some of the data is reported differently in that document.


3. Numbers for applications and orders granted represent increases of 9.8% and 10.1% respectively against a population increase of 6.3% from 2005 to 2011 (http://www.stats.govt.nz/).

4. Ministry of Health. Office of the Director of Mental Health: Annual Report 2007, Ministry of Health; 2008 (This data was reported for the first time in 2007).

During the two initial assessment periods (the first for up to 5 days and the second for up to 14 days) consumers can apply to have their compulsory assessment status reviewed by a Family Court or District Court judge.
At the conclusion of the assessment period a Family or District Court judge decides whether or not to issue a compulsory treatment order. If a compulsory treatment order is issued, consumers can apply to have their legal status reviewed by the Mental Health Review Tribunal.

Despite the number of applications received having increased, the number of applications heard by the Family/District Court and the Mental Health Review Tribunal and the numbers of successful applications for release from compulsory status have all decreased. The small number of patients seeking review under section 79, and the rarity of discharge decisions has previously been noted.3

The United Nations Working Group on Arbitrary Detention conducted a country visit to New Zealand from 24 March to 7 April 2014.

At the completion of that visit the Working Group held a press conference14 where they drew the Government’s attention to a number of issues of concern. In relation to the detention of persons with mental disability under the Mental Health Act they expressed concern that, in practice, compulsory treatment orders are largely clinical decisions, and difficult to effectively challenge. More specifically they identified that the Family Court 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.

Although the Mental Health Act guarantees the right to legal advice for all patients, the Working Group observed that persons undergoing compulsory assessments are often unrepresented in practice, as they do not have access to legal aid. They also expressed concern about the widespread practice of seclusion in psychiatric units. Whilst recognising the Government’s achievement in reducing the incidents of seclusion since 2009, the Working Group urged authorities to eliminate this practice.

There is a notable variation between DHBs in rates of use of the Act. In 2011 the rates of use of community treatment orders (CTOs, section 29) ranged from 33–151 per 100,000 per month; from 3–55 per month per 100,000 for compulsory inpatient treatment orders (section 30); and from 5 to 16 per 100,000 acute assessment and treatment (section 11).12

Rates of seclusion varied from 20–500 for seclusion events per 100,000 population; and ECT administrations without consent from 0-61%. The variability in use of the Act between regions suggests that the decision to invoke the Act might be governed not by a widely agreed ‘clinical necessity’ but more by locally determined administrative practice.

It is quite possible that the basis on which the figures have been collected have changed over time, affecting their reliability. However, whilst there might be different opinions as to the reliability of official data and the reasons for the apparent increases, these concerns about coercion demand attention. It is perhaps the lack of critical analysis that is the biggest issue.

In contrast to New Zealand, 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.
Whilst the increase in coercion is common to many countries, there is an apparent difference in response:

"It should be a source of considerable concern to the health and social care system in this country that use of the MHA continues to rise – despite the objectives of the national mental health policy and the investments in community services of recent years. We will be working across the system to consider possible changes to practice and policy that could result in a reduction or reverse to this trend".\textsuperscript{15}

**Changes in service philosophy**

Increases in use of coercion sit uneasily with other developments in mental health care over the last two decades. The treatment philosophy of recovery, in which service users are supported to live well in the presence or absence of continuing symptoms, is one of the most prominent of these developments.

Recovery philosophy explicitly supports individual autonomy.\textsuperscript{16} It is seen not only as good practice, but as the explicit Governmental goal of mental health services in New Zealand,\textsuperscript{17} as it is in the United Kingdom, the United States, Australia and many other developed nations.\textsuperscript{18}

If governmental commitment to recovery based services is to have effect, this needs to be reflected in the legislative framework supporting mental health services. Recovery philosophy explicitly recognises service users’ experiences of adversity, including compulsory detention and treatment, but also draws attention to how the mental health service system can give greater recognition to the service user voice, even in situations of crisis where compulsory treatment might be considered.

The current definition of mental disorder in the Act is antithetical to recovery because it implicitly suggests that people with mental illness pose such a degree of risk that this risk needs specific legislative recognition.

**The Convention on the Rights of Persons with Disabilities**

Recent developments in international human rights have important implications for mental health legislation internationally and within New Zealand. The 2006 United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) clarifies the application of human rights to persons with disabilities, including people with mental illness.

New Zealand has signed and ratified the UNCRPD, thereby assuming an obligation under international law to ensure and promote the full realisation of all the rights it contains. Within the UNCRPD the term ‘disability’ is given an inclusive meaning which incorporates all forms of physical, psychosocial and learning disabilities.

From the perspective of mental health legislation, the UNCRPD calls into question the legitimacy of legislation, such as New Zealand’s, which includes disability as one of its criteria.\textsuperscript{19}
Legislation which includes disability as a criterion is held to be discriminatory, an interpretation reflected in the following advice on mental health legislation from the Office of the United Nations High Commissioner for Human Rights (OHCHR):

Prior to the entrance into force of the Convention, the existence of a mental disability represented a lawful ground for deprivation of liberty and detention under international human rights law. The Convention radically departs from this approach by prohibiting deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory

….[Un]lawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person’s disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by article 14.20

New Zealand submitted its first report on implementing the Convention in March 2011.21 That report correctly noted that the threshold for compulsory care under New Zealand’s legislation is that the person concerned must be clinically assessed as having an abnormal state of mind, of such a degree that it poses a serious danger to the health or safety of the person or of others, or seriously diminishes the capacity of the person for self-care. On this basis, it was stated that the trigger for detention is not disability per se, but the risk of harm to self or others, so there is no breach of the Convention.

Based on the OHCHR explication of this matter, that interpretation is incorrect: the Act’s criteria for compulsion remains discriminatory because mental disability is still a central part of the legal test.

More recently the UN Committee on the Rights of Persons with Disabilities has taken a very definitive stand in response to the reports of a number of countries, including Australia, that have similar mental health legislation to New Zealand.22

In particular the Committee concluded that legislation allowing detention in a psychiatric facility “when [a person has] a psychosocial disability and it is forecast that they might endanger themselves or other persons” is in conflict with Article 14’s prohibition of deprivation of liberty based on an actual or perceived disability.23

The Committee advocated that countries should also take all measures to ensure that no one is detained against their will, on grounds of disability, in any kind of mental health facility.23 The Committee also urged that countries whose legislation includes the dual criteria of disability and risk should repeal these provisions,24 and should “abolish norms that authorise deprivation of liberty based on disability”.25

The Committee’s recommendations were not limited to detention in inpatient facilities, but included the more prevalent form of compulsion in New Zealand, community treatment orders.24

Given that New Zealand’s rate of use of CTOs is amongst the highest in the world,13 this opinion of the Committee is one of great significance in the New Zealand context.

Altogether, the CRPD and subsequent interpretations by UN committees signal a pressing need to review New Zealand legislation to reflect current human rights concerns.
Suggestions for reform

Commentators responding to challenges posed by the CRPD have proposed reforming legislation, most notably through the adoption of so called “fusion” legislation in which a single standard for capacity (or incapacity) is adopted across the health sector for all situations in which treatment is given without consent.26

Calls to abolish separate mental health legislation date as far back as 199427 and are based on an argument that treatment without consent should not be based on “status” (i.e. membership of a particular group) but on the patient’s capacity to give informed consent. Fusion law is based solely on impaired decision making capacity rather than what is believed to cause that incapacity. The same standard applies to the person with a diagnosis of schizophrenia, dementia or delirium, or the person with no diagnosis at all but who lacks capacity.

This approach to lack of decision making capacity addresses the issue raised by the CRPD that separate legislation with a criterion of disability is discriminatory.

Capacity standards for are not without their critics.28 Skipworth29 argues that a system based on capacity for treatment decisions (but not for detention) could prove problematic for forensic patients (people that have committed crimes and have experience of mental illness), particularly in terms of the impact on long-term prison to hospital transfers and the criminal courts potentially being unwilling to consider therapeutic dispositions if they are unable to secure treatment.

67.6% of a sample of forensic patients currently compulsorily treated under The Act were found to have treatment-relating decision-making capacity, and hence would not meet criteria for continued compulsory treatment under capacity based legislation.30

One of the arguments against introducing capacity-based legislation is that it could result in an epidemic of detained yet untreated patients in both prisons and mental health facilities and additional pressures for already overburdened systems. However, Skipworth et al30 found that very few of these people would refuse treatment, particularly if their liberty is at stake. They therefore conclude that there is no evidence to support the proposition that increased risks to third parties would commonly arise if there was a change to legislation based on capacity to consent to treatment. However the issue of whether even a small number of competent patients who will refuse treatment can be safely accommodated within tight budgetary constraints needs to be considered.

...because of the limited numbers, the risks of permitting treatment refusal by patients with capacity might be seen as manageable, and it may be considered that the disadvantages of that outcome are outweighed by the advantages of promoting patient autonomy if capacity principles are fully respected (p. 449).

In recent legislative reforms some jurisdictions have moved to introduce a capacity based standard31 however to our knowledge, none have so far adopted the “fusion” model of a single standard across the health sector. (A draft Mental Capacity Bill based on the fusion principle has recently been developed for Northern Ireland32.)

The fusion model proposes a single legislative vehicle, based on a capacity standard, for treatment without consent for both physical and mental illness.33 Such a model
would combine adult guardianship and civil commitment provisions within a unified legislative regime.

Kelly explains that such a change represents a radical departure from the present position, and there is little evidence that any jurisdiction, including the UK, is ready for such profound change. Arguably these are similar sentiments to those expressed when de-institutionalisation was first mooted. However, at least these jurisdictions have begun the discussions. If New Zealand values its reputation for socially progressive legislation this issue must be faced.

We have raised two main issues in this paper. First, use of compulsion, especially use of community treatment orders, appears to be increasing in New Zealand. Second, New Zealand’s mental health legislation, like that of other western countries could be considered to be in breach of our obligations under the UNCRPD. Legislative reform could address the second of these issues but is unlikely to address the first.

Experience has shown that the criteria of legislation is at best a blunt instrument for reducing rates of compulsion, with clinicians continuing to apply their own clinical and moral intuition in the face of legal criteria that are perceived as restrictive. But resistance to change is not a good reason to maintain the status quo.

While it might be expected that politics would not be an issue given successive Governments’ commitments to recognition of human rights, in a risk averse social and health climate such commitments will not necessarily trump domestic political whim. The literature on mental health commissions indicates that mental health reform is much more likely succeed with an independent monitor with influence at the highest levels of government.

Monitoring is essential to champion the transition to more evidence-based, community-centred, recovery-oriented, consumer, family and human rights-focused mental health services.

**Conclusion**

In the last 20 years the emergence and promulgation of the philosophy of recovery, subsequent policy endorsement of that philosophy, and international human rights developments, have significantly altered conceptualisations of humane treatment of people with mental illness.

New Zealand’s mental health legislation is now in conflict with the philosophical approach required by Government; and in breach of our international treaty obligations. At the same time, compulsion under mental health legislation in New Zealand appears to be increasing, and it is questionable how effective the mechanisms for challenging detention are in practice.

Moreover, monitoring of the situation at the systemic level lacks critical analysis. There is no indication that a review of the Act is nigh. So, just like 100 years ago, many people with experience of mental illness find themselves taken charge of, and managed, by a State that is not fulfilling its concomitant moral, ethical and political duties to ensuring the most humane treatment of people with mental illness.
Consequently New Zealand’s mental health legislation is in urgent need of review and reform. In the meantime, current reporting of rates should continue, with critical analysis of trends over time and of variation between regions.

Competing interests: Nil.

Author information: Sarah E Gordon; Anthony O’Brien. Department of Psychological Medicine, University of Otago – Wellington, Wellington

Correspondence: Sarah E Gordon, Department of Psychological Medicine, University of Otago Wellington, PO Box 7343, Wellington 6242, New Zealand. sarah.e.gordon@otago.ac.nz

References:


