The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

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Tēnā koe John

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

Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide comment on the proposed draft revision of the Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Guidelines).

This response has been prepared by the RANZCP's Tu Te Akaaka Roa/The New Zealand National Committee (NZNC), and informed by Faculties and Committees specialising in Forensics, Old Age, and Children and Adolescents, as well as by:

- Māori perspectives[1]
- the views of consumers with lived experience
- the expertise of psychiatrists whose speciality is neuro-stimulation and alternative techniques.

Central to the mahi of RANZCP is the development of best practice standards (e.g. The RANZCP Code of Ethics[2]; Position Statement 86: Recovery and the Psychiatrist[3]) which aim to provide psychiatrists with a consistent, shared understanding of concepts relevant to psychiatry and of the practices the RANZCP support within the delivery of mental health care.

Four key platforms also articulate and underpin the philosophy of the NZNC:

- **Don't forget the 5%** – irrespective of other priorities, the nation's most vulnerable and chronic mental health and addiction service patients[4] must receive the seamless care they require.
- **Let's work together** – patients must be placed at the centre of care; we advocate for increasing support to meet patients and communities' needs by broadening the range of community-based services and we hold this is particularly important for at-risk, rural, and isolated communities.

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- **Look at the evidence** – to ensure cultural safety/competency, efficiency and efficacy, policy and service delivery must be underpinned by the highest quality New Zealand and international evidence.
- **Get the right people in the right places** – the care and support patients require must be accessible when and where needed and delivered by the most appropriate workforce, whether that is a highly skilled psychiatrist, another qualified health professional, whānau or peer/community groups.

Overview

The NZNC acknowledge the intent of the Guidelines is to ensure principles of Te Tiriti o Waitangi and rights-based / recovery approaches are better integrated in care and treatment delivered under the Act.

The NZNC support expectations to deliver culturally responsive care (4.1.1) and acknowledge the historical role of underlying institutional racism experienced by ngā tāngata whenua. We note ongoing concerns of the effect of racism are reflected in the findings of the HQSC[5] which suggests a rights-based approach would work if it is integrated into legislation.

However, we hold the Act is outdated, no longer reflecting best practice in New Zealand (see for example, page 6: novel biological treatments) and that this presents a risk to patients. Fundamentally, we are concerned revising Guidelines for an outdated Act may not improve outcomes.

We consider:

- there is urgency to undertake a review of the Act
- incremental revisions through Guidelines may, rather than add clarity to practice:
    - further increase confusion and inconsistency
    - lead to unintended consequences.

In lieu of starting fresh with a full review of the Act, the NZNC hold the Guidelines should:

- provide clarity regarding the current legislative framework and existing framework
- not attempt to align outdated legislation, e.g. the Personal and Property Rights Act 1988, with the existing Act.

Key points regarding the Guidelines

The NZNC notes tensions which may potentially undermine the likelihood the proposed Guidelines will achieve the intended outcomes. As written the document:

- appears more prescriptive than as guidance
- may impinge on clinicians' ability to exercise clinical judgement
- intimates an unhelpful view of the compulsory nature of the Act and, by default, of clinicians applying the Act (e.g. the document uses the word 'coercion' seven times).

In some areas, the Guidelines imply an expectation of compliance and may result in practitioners being caught between the law and Ministry of Health advice in circumstances where the advice does not match best practice (see page 5: Compulsory Treatment Orders (CTO) and 'necessity').

Key recommendations

The RANZCP considers first steps toward improved outcomes under the current Act would be:

1 to seek clarification from key stakeholders, including clinicians, about problem areas
2 to address the attitudinal divide identified above by:
2.1 addressing the different realities and perspectives of all parties
2.2 actively working to build the mutual trust and goodwill that is requisite to effective service delivery.

Recognising strengths and limitations of legislation and guidelines will assist in developing more relevant policy. Within this context, we recommend:

3 ensuring evidence-based, legislative reform precedes all prescribed practice changes.

4 revising the proposed Guidelines to:
4.1 address inconsistencies and impracticalities as noted in the following pages (especially regarding resource / personnel constrained environments), such as:
4.1.1 obtaining second opinions
4.1.2 the application of 'necessity' when considering CTO reviews
4.1.3 gaining consent before s59 is invoked
4.1.4 privacy risks associated with transfer of clinical data, e.g. email - if this is to remain the recommended method of communication
4.2 ensure, if changes are made in the use of terminology or definitions, these changes are explicit
4.3 articulate expectations around applying the Act when a person is considered not competent to decide
4.4 include section/s to assist clinicians at times of necessity or urgency.

5 reviewing the language and structure of the Guidelines to ensure they:
5.1 are evidence-based and less prescriptive
5.2 are user friendly and succinct
5.3 contain an executive summary within each section, with key messages highlighted
5.4 tautoko the translation of the Act into te reo Māori.

Specific issues and recommendations

1 Rights-based and risk-based recovery approaches

The NZNC suggests that it is most useful to view risk and recovery models as complementary and improvement focused. Addressing risk promotes safety and recovery, and the 'least restrictive principle' guides the 'managing of risk' in practice.

2 The impact of resource and time constraints

'Patchy' or inconsistent levels of service between DHBs arose as themes in feedback provided to the NZNC from Māori and from lived experience (patient/whānau) groups invited to contribute to this response; psychiatrists' feedback also underscored those reports. While research has found language and cultural issues are the two most widely experienced barriers to *service utilisation*[6] the NZNC suggests the most pervasive and widespread barriers to *service delivery* are access to resources (e.g. interpreting

services). Findings from the HQSC[7] tautoko this view. Optimal service delivery requires well-funded services with good liaison to acute general psychiatry in all DHBs.

3 Practicalities in implementation/mechanics

While the NZNC is sympathetic to the concept of value-free service delivery, we are unsure whether the following proposed procedures will achieve that:

3.1 Obtaining a second opinion from a psychiatrist in another DHB

In personnel and resource-constrained environments we submit that it is impractical for the Guidelines in 10.1.2 to recommend an s59(2)(b) second opinion is obtained from another DHB. Reasons cited by clinicians note:

3.1.1 achieving second opinions in a timely matter is already problematic within DHBs and the logistics of working across DHBs can also be difficult

3.1.2 unnecessary repeated second opinions are a risk to an already pressured workforce

3.1.3 ECT clinicians find it challenging to identify which responsible clinicians are certified and available to undertake s59 & s60.

3.2 Ensuring a "non-prejudicial second opinion"

Clinical judgement is an integral part of practice, informed by evidence, best practice and experience. Clinicians are expected to acknowledge and address biases within reflective practice. We note: a second opinion could convert s60 (consent to be treated with ECT) to compulsory s60(b) ECT; such a revision would contravene the least restrictive principle.

4 Supported Decision-Making and Capacity

Research published in 2011[8] identified seven main themes, which collectively influence decision-making processes in psychiatry:

4.1 information gathering

4.2 training in psychiatry

4.3 intuition and experience

4.4 evidence-based practice

4.5 cognitive reasoning

4.6 uncontrollable factors

4.7 multidisciplinary team influences.

While no single approach to decision-making was identified, it was clear that decision-making is influenced by the level of clinical experience, clinical judgement, and external pressures, such as time and treatment availability.

5 Increased documentation

We caution that expectations of increasing documentation compromise already limited time. Trade-offs within time-constrained environments are inevitable and the NZNC suggests the Ministry of Health could work with clinicians to explore patient-centred expectations.

6 Managing patient expectations

The NZNC recognise issues of patient frustration and feelings of being disempowered in certain areas (e.g. the application of advance directives). We hold there must be more collaborative work and greater understanding of complexities around practices. In keeping with the RANZCP's commitment to patient-centred care, we encourage patients to develop advance directives when they are well.[9] Such strategies can give people more choice and control over their lives and their treatment during exacerbations of their mental health conditions. The Guidelines, we submit, provide an opportunity to clarify

best practice; the statutory recognition of advance directives will benefit people with mental health conditions.

7 Recovery

While all patients within mental health services can expect recovery, there will be variations as to the level and the timing of that recovery. Some patients with chronic, severe, relapsing conditions may need to remain with support for their life course. The RANZCP considers the role of the mental health practitioner is to support the patient and their whānau to optimal recovery.

We submit reframing the Guidelines to facilitate collaboration across jurisdictions, including community and whānau, will be more likely than a prescriptive approach to improve outcomes for people with enduring mental health issues. Collaboration would provide a greater level of trust and, consequently, facilitate efficacy.

8 Inconsistencies

8.1 **Special patients and timeframes** are provided for in the Act and through Mental Health Review Tribunal (MHRT) processes, however there are no timeframes for the Ministry of Health to respond on significant compulsion issues e.g. an application for a change in status for a special patient. Considering the RANZCP Position Statement 93 on involuntary mental health treatment in custody may be useful.[10]

8.2 **Expectations.** 14.7.2 states that services must address environmental issues driving the use of restraint. Noting, many mental health units are not built as a 'fit for purpose' space, it will be difficult to address these issues; it is important to consider the full context.

8.3 **Provision of interpreters**. We seek clarity on the advice in 4.2 s6 regarding using 'amateurs' for translation and submit this guidance is contrary to best practice. The RANZCP take the position Culturally and Linguistically Diverse (CALD) carers should not be expected to act as translators during medical consultation.[11]

8.4 **Compulsory Treatment Orders (CTO) and 'necessity'.** The proposed Guidelines suggest 'necessity' is a statutory criteria and is appropriate for the Responsible Clinician (RC) to apply to their CTO reviews. This guidance seems inconsistent both with the current Act, and with commonly known case law which states the initiating judge needs to be satisfied of the 'necessity' for an order before making a CTO but suggests for the RC to do so is in fact inappropriate (see Court of Appeal vs H). The NZNC notes, in some cases, indefinite Compulsory Treatment Orders (CTOs) are repeatedly extended without judicial or MHRT review, for years. Whether CTOs are necessary in all these cases has been questioned. Yet, the advice within the proposed Guidelines is at odds with sector understanding.

9 Language and tone

The NZNC considers the central purpose of this Guideline is to provide clarity around application of the legislation, without crossing into areas of clinical judgement. We submit for example, the difficulty posed by section 9 (2)(d) of the Act which 'requires a support person must be present'.

The RANZCP considers 'mandating' or prescribing practice within a guideline document is inappropriate; we offer as a salient example, page 79, 7.6 (mandating the responsible clinician to tell their patients they are not allowed to travel). The language used here and elsewhere might be reviewed to:

9.1 recognise the clinician's judgement and ability to appropriately manage consultation e.g. it is not necessary to advise clinicians to take a collaborative approach
9.2 be less prescriptive
9.3 consider whether the advice puts the RC in an untenable position, such as the effect on the RC if the patient travels despite being informed about the risks.

We query the tone of the Guidelines, e.g. 'must' appears 152 times within the Guidelines.

10 Changing from 'abuse' to 'use'

We note in 3.1 substance 'abuse' changes to 'use'. While the word 'abuse' is used in our current Act, it does not appear in DSM 5 nor in the Substance Addiction (Compulsory Assessment and Treatment) Act). However, with the commonly understood meaning of 'abuse' as 'maladaptive' or 'harmful' use, we query whether it is appropriate for the proposed Guidelines to replace 'abuse' with 'use.'

11 Definitions

Mental disorder – the definition of mental disorder is incorrect and needs amendment
Recovery – see above (point 7 page 5).

12 Gaining consent prior to s59

We were unable to find reference within the proposed Guidelines regarding different requirements for gaining consent in the period before s59. We query the intent of the expectation that consent procedures be standardised. If so, this expectation must be explicit and clarified.

13 Novel biological treatments

More guidance on treatments that improve a patient's experience is needed to ensure they get access to evidence-based and best practice care. Some treatments now in use in New Zealand, e.g ketamine, can be more intrusive than some medications and talking therapies, and lead to periods of disassociation or decreased alertness. For the Guidelines to be current and relevant, we suggest there must be a section which considers the impact of treatment of novel biological treatments.

14 Reference to the Intellectual Disability Compulsory Care and Rehabilitation (IDCCR)

We submit it is important the Guidelines note (3.2), while the IDCCR and the Act can be in place concurrently, the Act overrides the IDCCR in such cases.

15 Attention to privacy issues

While 11.1 recommends emailing of information, it does not clarify or reflect on the privacy risk inherent in this practice; if sending clinical data via email is to remain the recommended method of communication, we submit the Guidelines should include a discussion to determine whether the solution is a risk for the patient.

16 Guidelines for clinicians

We suggest it would be useful to add sections within the Guidelines outlining means of obtaining Ministry of Health support:
16.1 in the face of untenable workload priorities due to resource/funding/time constraints
16.2 at times of necessity or urgency.

In summary

The RANZCP considers the intent of the Guidelines should be to focus on improving clarity of the current Act and should only assist with application of the Act as it stands. We caution the practical implications of some mandated actions which may be significant and should be reconsidered as consultation material for a future Act. We recommend a cautionary note be added that the Guideline may change once the new Act comes in force. Proposed additions have significant funding and resource limitations, and some are exacerbated by time constraints. In addition, we note the shortage of specialist services across New Zealand will cause pressure across the mental health system if proposed guidance listed as 'must' becomes mandatory.

Our response acknowledges the perceptions of mental health consumers and underscores our recommendations for improving patients'/whānau understanding, managing expectations of timeframes, treatments and outcomes. It reflects the perspective of psychiatrists engaged in clinical practice.

The NZNC holds the purpose of guidance is to increase understanding and transparency. To achieve this, interpretation must not be prescriptive and must assist clinicians to minimise risk to consumers and their whānau.

Increasing trust and understanding for consumers and their whānau, and improving quality of services through improved clarity must be the goal of the Guideline. In a climate lacking in autonomy, this goal will not be achieved. Increasing understanding of a person's condition, environment, and their whānau circumstances at the time of treatment will assist them to reframe their thinking in situations currently viewed as disempowering and to develop greater trust in the expertise and judgement of their healthcare provider.

We support and reinforce the need for a Guideline to improve understanding on all levels, but we suggest giving particular attention to sector relationships, and the tone of the document; ensuring inherent expectations, and how the Act is used in practice, can subsequently make a difference to expectations of recipients of this treatment and their whānau.

If you have any questions regarding this submission please contact Rosemary Matthews, National Manager, New Zealand, on 04 472 7265 or by email Rosemary.Matthews@ranzcp.org.

Ngā mihi nui

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References

[1] The RANZCP sought feedback from external consultation groups: Māori and consumers with lived experience.
[2] The Royal Australian and New Zealand College of Psychiatrists. Code of Ethics (2018). Available at: https://www.ranzcp.org/files/about_us/code-of-ethics.aspx Viewed 7/01/2020.
[3] The Royal Australian and New Zealand College of Psychiatrists. Position Statement 86: Recovery and the Psychiatrist (March 2016). Available at: www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/recovery-and-the-psychiatrist Viewed 7/01/2020.
[4] Note: the RANZCP would typically not use the word 'patients' but rather would refer to people with lived experience or consumers of mental health services. For the purpose of this submission we have adopted the language used in the Act and the Guidelines.
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[7] ibid
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[11] The Royal Australian and New Zealand College of Psychiatrists. Position Statement 76: Supporting carers in the mental health system (December 2012). Available at: https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/supporting-carers-in-the-mental-health-system Viewed 7/01/2020