



Submission on the Repeal and Replacement of the Mental Health Act

Prepared by

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Mind and Body

January 2022

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Who are we?

Mind and Body is a national organisation, focused on the delivery of peer support and advocacy services for people who experience mental distress, internalized stigma, prejudice, and discrimination. We also offer consultancy services that support the growth and development of peer services and lived experience thought leadership.

As an organisation we support and work to amplify the worldview of the many unique communities we are of service to across Aotearoa New Zealand. One of our strategic objectives is to support the full participation of people as citizens of their communities, with the strong connections and a sense of belonging that would make this possible.

This submission is informed by the voices of the people who work for, with and alongside Mind and Body.

Introduction

In health care, the area of mental health care is the only area where forced treatment has been the norm and one where when individual choice around treatment conflicts with the perceptions and choices of others, be that psychiatrist or whānau, the choices of the individual are overridden with "Treatment Orders".

Whilst the motivation for using the Mental Health Act is usually construed by those who apply it, as preventing harm, the voices of people who have been subjected to this practice refute such claims. The mere act of being "sectioned" or placed under the Act has been described as traumatizing, harmful and degrading.

Mental health legislation has been used for decades as a means of control, particularly in cases of perceived risk. The use of legislation in the care and protection of people who live with acute mental distress has impacted most aspects of mental health care - from compulsory care in the community to compulsory inpatient surveillance and care.

The link between psychiatry and law has created what we see as an unwelcome dynamic within mental health care. This dynamic perpetuates coercive and medicalised practices and ultimately does not support the building of relationships of trust, which creates a safe and therapeutic milieu. (Gilbert, Rose & Slade, 2008).

***"My experience of being placed under the Act has left me
feeling less human"***

People who live with significant mental distress deserve to be treated with respect, compassion, and generosity; they deserve to experience treatment and care within trusting relationships that are free from coercion and support people's self-determination.

Te Tiriti o Waitangi

Mind and Body is a Tangata Tiriti organization. We will not speak on behalf of Māori and raise our concerns based on our experiences as an organization working alongside Māori.

Our experiences and observations are that Māori experience discriminatory practices under the Mental Health Act, perpetuating health inequities, human rights breaches and the erosion of tino rangatiratanga. The ongoing use of a medical model, westernized approaches that do not accommodate te ao Māori and in fact often cause harm, is not acceptable and needs to be addressed with urgency.

Our perspective is that the application of Te Tiriti o Waitangi extends to ensuring equitable health and wellbeing outcomes for Māori, and to foster tino rangatiratanga. We support every effort that will ensure Te Tiriti o Waitangi principles underpin all systems, processes and legislative requirements relating to Māori health and wellbeing.

From our perspective, whānau-centred approaches, and approaches that allow for the incorporation of te ao Māori and tikanga Māori in legislation, are essential. We believe legislation itself needs to support ways to do things differently as we do not believe that we will see adequate changes to systemic processes unless the law explicitly requires this, and intentionally incorporates Māori principles, values, and practices.

The Purpose of Mental Health Legislation

According to a study self-stigma, associated stress and a reduced empowerment from coerced treatment predicted a poorer quality of life and lowered people's self-esteem. (*Rusch, Muller, Lay, Corrigan et al 2014*)

Involuntary treatment is stated to be used to prevent the risk of someone harming themselves or others. Studies have clearly shown that predicting someone's risk as is an inaccurate and inexact practice. In the current system, it makes sense for doctors and therapists to err on the side of caution, but there is a strong chance for the breakdown of trust between the mental health professional and person if they are forced into compulsory treatment of any nature, ultimately causing more harm.

We believe mental health legislation should be focused on the protection of the legal and human rights of the people who live with mental distress. Only second to this should be the interest of the public.

We see the current application of mental health legislation as harmful to relationships and eroding the use of relational care strategies in mental health treatment, care, and support.

As an organization we support the exploration of having no compulsory treatment in Aotearoa and therefore removing the Mental Health Act in its current form.

The Trieste model of no restraint, focusing on a move from a clinical model based on treating illness to a wider approach focused on fostering belonging and social inclusion has been evidenced to work – fewer than 10 in a 100,000 of the population received a compulsory treatment order, and usually for only 7-10 days. (*Compendium Report: Good Practices in the Council of Europe to promote voluntary measures in Mental Health, 2021*)

We would be supportive of exploring how mental health legislation can instead be focused on the provision of services, optimized systems and processes which encourage health care strategies focused on building holistic wellbeing through strong relationally focused approaches, devoid of harmful power dynamics.

We would want to see legislation, systems, and strategies that

- ✓ Are free from coercion or compulsion, seclusion, and restraint, prioritizing the respectful treatment of people with significant mental health concerns, without recourse to incarceration in the health or justice systems
- ✓ Are mana enhancing and upholding people's human rights
- ✓ Are firmly grounded in a sound, evidence based public health approach focused on prevention, early intervention, prevention of premature death, and growing healthy whānau and communities.
- ✓ Allow people pathways of accessing treatment, care and support that address their cultural and whānau needs
- ✓ Do not traumatize parties nor perpetuate prejudice, stigma, or discrimination, or reduce people's mana
- ✓ Support relational treatment, care, and support approaches that are focused on recovery and wellbeing, and uphold relational safety first and foremost

- ✓ Require the presentation of options to the person and guarantee availability of advocacy services
- ✓ Treat mental health as a health issue rather than a risk issue and focus on the causes of any crises not only the effects.
- ✓ Prioritize self-determination and allow advanced directives to the extent of requiring explicit documentation and rationale in detailed processes
- ✓ Recognise and respond well to the concerns and support needs of whānau
- ✓ Hold those who apply the law accountable to both the people affected by the law and their whānau and an external monitoring agency.

We considered the use of any compulsion to potentially be only two-fold

- ✓ Explicitly at the request of the individual and their whānau, and directed by clear, unambiguous advanced directives
- ✓ For assessment purposes (excluding treatment) and limited to a brief period of review (no more than seven days) to determine future options and next steps. These future options should be considered by the person alongside their whānau and potentially with the support from an advocate.

Where compulsion is considered, we suggest processes should take place within an Open Dialogue approach, within a healing environment that removes the powerful and negative dynamic created by the interplay of psychiatry and the legal system.

The 'Open Dialogue Approach to Acute Psychosis' is a Finnish practice that is now operating in countries as diverse as Norway, Denmark, the UK, Italy, Portugal, Germany, Poland, the Netherlands, USA, and Australia. Care decisions are made in the presence of the individual and her/his wider networks. Psychotherapeutic approaches are taken to promote dialogue between the person and her/his support network.

Capacity and Decision-making

Deciding not to engage with treatment can be an entirely reasonable decision, considering that compulsory treatment options are too often centered around the use of medication. There can be serious side effects to such treatment as anti-psychotic medication has proven to contribute to irreversible, negative health conditions and increase the risk of early death or dementia. Unfortunately, when it comes to one's mental health, informed consent is not required from people

who are compelled to undergo treatment that are perceived to impose a significant risk to one's health, unlike what is experienced in the rest of the health sector. Proponents of compulsory treatment claim that this difference is due to the lack of ability to make a sane decision during psychosis, and thus during psychotic episodes, professionals need to decide over the patients' lives.

We would argue against the above statement. We propose that 'sane decisions' are decisions based on subjectively selected arguments. Hence, gaps between professional and individual assessments of any one situation would be quite common. In physical illnesses such as cancer, many patients decide to take part in a treatment despite medical opinion proving it is not evidence-based or refuse treatment despite medical opinion that it is needed – and all these decisions are based on purely personal beliefs and fears, or even religious grounds. Such patients' capacity to make decisions over their own future is not questioned, even though fear of death or fear of pain might also alter one's perception and judgment.

It is generally accepted that decision-making capacity is not fixed and approaches to addressing decision-making capacity should therefore be agile and responsive. We support the approach that no psychiatric treatment should take place without the informed consent of the individual, or whānau in the case of minors.

Where decision making capacity is in question, it is important for advanced directives to be used in collaboration with whānau and/or advocates. We would again recommend a move to Open Dialogue approaches in supporting decision-making.

Additionally, we would envisage the availability of an advocacy and support system which offers personal support and individual advocacy for persons experiencing crisis or temporary disruption to their decision-making capacity. The 'advocates' would be statutorily appointed to assist a person to make decisions in a facilitative rather than coercive fashion.

Seclusion, restraint, and other restrictive practices

The use of restraint to control behaviour occurs in a wide range of institutional and other settings in Aotearoa and around the world. These practices are controversial due to the adverse physical and psychological impacts that may result, particularly as some forms involve serious deprivation of freedom and autonomy, interference with personal integrity and loss of dignity. Our stance is the seclusion and restraint should be eliminated.

The practice of physical and other restrictive practices has been named as a particularly traumatic part of "treatment" by people with lived experience. Negative effects can include psychological and physical harm, damage to the therapeutic relationship, and violations of human rights. Staff may

believe they are protecting the individual in the short-term, but the long-term effects could be detrimental, flying in the face of a nurse's ethical responsibility to prevent harm and uphold peoples' rights to autonomy. While the practice may be state sanctioned, the physical, emotional experience and sequelae may be like assault.

The use of trauma informed approaches and developing a framework that require trauma competence amongst all staff would be an essential step forward. This requires a cultural shift that incorporates a focus on strengths and skills building rather than behavioural control. Changing nursing care practices and the associated culture on acute psychiatric inpatient units requires imagination, determination, and commitment by individual health professionals as well as leaders of health services, to be successful and sustainable. Policy and clear guidance around restrictive practices are essential to ultimately eliminate the use of such practices within inpatient units. Even the transportation of people to inpatient units by police needs to be reconsidered in terms of restrictive practices

We know there will be submissions to this Act where people will share stories that will highlight perspectives of physical restraint and compulsion under the current legislation being the "only option" to prevent harm to the person. In some cases, people may even express some gratitude for these steps. We believe that this "only option" viewpoint is heavily influenced by the resources that would have been available to the person and their whānau along their journey, culminating in crisis. We believe additional resources for community and whānau, and shifted accountabilities under legislation (and therefore directions taken) would provide different outcomes in a vast majority of cases.

We also know that there has been considerable rhetoric about the safety of staff in inpatient wards, particularly where people may be experiencing extreme distress, confusion and or transient psychosis as an immediate result of drug taking, i.e., methamphetamine psychosis. We suggest that better outcomes for all, including staff, would be seen with the provision of resources and processes that support adequately the needs of those experiencing an extreme drug reaction. In short, we don't believe it serves individuals, staff or others present on the ward, let alone the cause of the for people who are experiencing significant mental distress.

It is important to note that neither voluntary nor compulsory admission into a hospital necessarily means that the person will undergo 'treatment' there, even if relatives and friends believe that this is the case. Patients often spend weeks in a hospital without other therapies than medication. We would therefore recommend that a "de-institutional" approach be adopted where the restrictive use of hospital treatment in closed or locked wards, are reduced significantly and replaced by community-based, whānau-centred options that include

- ✓ Peer alternatives – advocacy, support, and acute alternatives
- ✓ Home-based treatment options and alternatives

Review of legislation, systems, and processes

To avoid scenarios where any legislation is not fit for purpose or implemented adequately, we would recommend that any future legislation, systems, processes, and implementation of these be reviewed at least every five years, and this be done by an independent body or agency that can hold instances to account on the application of the Act. Alongside this we would recommend that an independent Māori monitoring entity be established that focus solely on how legislation impacts and supports Māori.

In Conclusion

In theory compulsory treatment is put in place to protect people's lives and treat their 'illnesses,' yet the reality is that involuntary treatment does not result in recovery – in fact, people's experiences show that it is the cause of many irreversible problems and that being involuntarily treated is a traumatic life experience that usually makes people feel overpowered by external forces; hence, rather than help, it contributes to even greater distress.

We do not dispute that people experiencing different realities or significant distress may need some sophisticated interventions, but the way this is done now can and needs to be swiftly changed. Studies, human rights recommendations, and personal testimonies all suggest that compulsory treatment by medication alone, seclusion and restrictive practices do not treat poor mental health and significant mental distress nor does it promote wellbeing.

We want to offer this as a final thought

"There is no such thing as forced healing"