Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992

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Abbreviations

Amendment Act	Mental Health (Compulsory Assessment and Treatment) Amendment Act 2016
CP(MIP) Act	Criminal Procedure (Mentally Impaired Persons) Act 2003
CRPD	Convention of the Rights of Persons with Disabilities
Code of Rights	Code of Health and Disability Services Consumers' Rights
DAMHS	Director of Area Mental Health Services
DAO	duly authorised officer
DHB	district health board
IPCA	Independent Police Conduct Authority
Mental Health Act	Mental Health (Compulsory Assessment and Treatment) Act 1992
NZBORA	New Zealand Bill of Rights Act 1992
RANZCP	Royal Australian and New Zealand College of Psychiatrists
Review Tribunal	Mental Health Review Tribunal
SOGIESC	sexual orientation, gender identity and expression, or sex characteristics
SPEC	Safe Practice Effective Communication
Substance Addiction Act	Substance Addiction (Compulsory Assessment and Treatment) Act 2017
UNCROC	United Nations Convention on the Rights of the Child

Contents

Executive summary

He Ara Oranga: The report of the Government Inquiry into Mental Health and Addiction (Government Inquiry into Mental Health and Addiction, 2018) recommended replacing the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act or the Act) with new legislation that:

> … reflects a human rights approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment. (recommendation 34)

In 2019, the Government agreed to repeal and replace the Mental Health Act. As work on this repeal and replacement progresses, it is our collective responsibility to ensure the current Mental Health Act is applied in a way that respects and promotes a person's rights and places human rights principles at the centre of service provision.

Human rights are the basic entitlements and freedoms that belong to every person, including dignity, fairness, equality, respect and independence. We are all equally entitled to our human rights without discrimination. Universal human rights are often expressed and guaranteed through domestic and international law.

The Mental Health Act restricts people's rights through the use of compulsory assessment and treatment and other restrictive practices. Despite operating under the current Act, however, services and individuals have opportunities to better align their decision-making and clinical practice with domestic and international human rights obligations.

People with lived experience of the Mental Health Act have consistently indicated that they want greater recognition of their views and preferences and to experience less coercion, in accordance with their human rights (Government Inquiry into Mental Health and Addiction 2018; Ministry of Health 2017). An underlying principle of the Mental Health Act is to apply the least restrictive approach, so that those who administer the Act minimise the infringement on people's rights.

This document provides guidance on how to think about and apply human rights, recovery approaches and supported decision-making when implementing the current Mental Health Act. Please read it together with the Guidelines on the Mental Health (Compulsory Assessment and Treatment Act) 1992, 'Chapter 6: Part 1: Compulsory assessment and treatment' (Ministry of Health 2020a).

Section 1: Rights-based and recovery approaches

Both rights-based and recovery approaches to mental health are considered good practice in mental health and addiction care and treatment. They are reinforced through domestic and international law.

A **rights-based approach** to mental health promotes and protects human rights in policy and in services, including a person's right to autonomy, dignity, self-determination and tino rangatiratanga.[1] A rights-based approach to mental health means that a person remains central to all decisions that affect them, including decisions about their treatment and care.

In a **recovery approach**, mental health professionals work towards 'supporting an individual to improve their health and wellbeing, live a self-directed life and strive to reach their full potential' (Te Pou o te Whakaaro Nui and Ministry of Health 2018). The recovery approach is the predominant paradigm in Aotearoa New Zealand mental health policy and practice.

The recovery approach is consistent with a human rights approach to mental health because it:

> … respects people's rights and autonomy, acknowledges their strengths and supports social connectedness, hope, empowerment and positive risk-taking. It also takes into account all of the social determinants of mental health, such as relationships, education and employment (i.e. all the elements of a person's life which have meaning, and which can have a positive or negative impact on their mental health. (World Health Organization 2019)

Taking the least restrictive approach to a person's treatment and care by minimising the use of compulsory treatment and coercive practice is also consistent with both rights-based and recovery approaches to providing mental health services. In addition, it is an implied purpose of the Mental Health Act. We explain it in more detail in this section under the heading 'Taking the least restrictive approach'.

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[1] Tino rangatiratanga means self-determination or sovereignty. Māori are guaranteed self-determination and mana motuhake (the right to be Māori and to live on Māori terms following Māori philosophies, values and practices).

Domestic human rights law and the Mental Health Act

Rights set out in the New Zealand Bill of Rights Act (NZBORA), the Human Rights Act 1993 and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Code of Rights) apply alongside the Mental Health Act, except where a legal obligation, duty or authorised act expressly overrides them.

The NZBORA and the Human Rights Act 1993 give expression to Aotearoa New Zealand's international obligations in domestic law. The Code of Rights is the mechanism for protecting people's rights in relation to health and disability care.

Compulsory treatment under the Mental Health Act can impact the NZBORA right:

- not to be subject to torture, or to cruel or degrading or disproportionately severe treatment or punishment (section 9)
- to refuse to undergo medical treatment (section 11)
- for everyone deprived of liberty to be treated 'with humanity and with respect for the inherent dignity of the person' (section 23).

The rights set out in the NZBORA are not absolute. They are subject 'only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society' (section 5). In exceptional circumstances, it is necessary to restrict a person's rights in order to protect that person or the rights of others. The question to ask in each case is: 'would a certain limit on rights be proportionate in the circumstances? If so, it may be justified' (Dawson 2015).

The Code of Rights sets out 10 rights that apply to 'every consumer' of health and disability services. These rights are:

1. to be treated with respect
2. to freedom from discrimination, coercion, harassment, and exploitation
3. to dignity and independence
4. to services of an appropriate standard
5. to effective communication
6. to be fully informed
7. to make an informed choice and give informed consent
8. to support
9. in respect of teaching or research
10. to complain.

Where the Mental Health Act overrides a Code right (such as Right 7 to make an informed choice and give informed consent) in part or in full, all other Code rights continue to apply. Other Code rights (including the rights to dignity and independence, to be treated with respect, to effective communication and to support) are particularly important and relevant where the Act overrides a Code right.

The Mental Health Act limits the right to refuse to undergo medical treatment. Because of this significant infringement on individual autonomy and freedom, the Mental Health Act includes several safeguards and independent monitoring mechanisms to protect patients' rights.

International human rights law and the Mental Health Act

Aotearoa New Zealand is a signatory to several international agreements that are relevant to the rights of people receiving compulsory mental health treatment. These agreements include:

- the United Nations Convention on the Rights of Persons with Disabilities (CRPD)
- the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- the Declaration on the Rights of Indigenous Peoples
- United Nations Convention on the Rights of the Child.
- Other relevant United Nations conventions include the Convention on the Elimination of All Forms of Racial Discrimination and the Convention on the Elimination of All Forms of Discrimination Against Women.

Convention on the Rights of Persons with Disabilities

The CRPD reflects an international movement towards giving greater recognition to the rights of disabled people, including people with psychosocial disabilities (that is, disabilities related to the functional impact, particularly social and economic, of a mental health condition). It creates obligations on countries who have signed it, including Aotearoa New Zealand, to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by people with disabilities, including people experiencing psychosocial disabilities and mental ill health. Aotearoa New Zealand ratified the CRPD in 2008.

The CRPD adopts the social and human rights models of disability, which means that disability is not attributed to the individual; rather, 'disability' is a result of barriers that the social, political and physical environment create, which restrict people in exercising their human rights and prevent inclusion. Under this model, medical intervention is a means to support people to undertake the activities they want to, and to participate in society if they find it helpful, rather than such participation being an end in itself (World Health Organization 2019).

Key CRPD rights relevant to compulsory treatment are:

- the freedom to make your own choices (Article 3A)
- equal recognition of people with disabilities before the law (Article 12)
- the right to be free and safe and not deprived of freedom arbitrarily (Article 14)
- freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16)
- treating people with disabilities as people first (Article 17)
- the right to good health and health services 'on the basis of free and informed consent' (Article 25).

Article 12 is a key article of the CRPD. It states that people have the right to:

- make their own decisions and fully enjoy their legal capacity (ie, the right to **hold** rights and the right to **exercise** these rights)
- access the support they may need to help them make decisions
- appropriate and effective safeguards to prevent abuse in accordance with international human rights. Such safeguards must ensure that measures relating to the exercise of legal capacity:
  - respect the rights, will and preferences of the person
  - are free of conflict of interest and undue influence
  - are proportionate and tailored to the person's circumstances
  - apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body
  - are proportionate to the degree to which they affect the person's rights and interests.

The Mental Health Act and the CRPD

All agencies, services and health practitioners responsible for implementing the Mental Health Act should be considering how they can apply Article 12 in their practice and processes, within the limits of the Mental Health Act. It is true that the Mental Health Act conflicts with the CRPD by allowing a second-opinion psychiatrist to override a competent person's refusal to receive treatment (section 59(2)(b)). Within this context, however, it is important that:

- the person whose consent is sought under section 59(2)(a) is fully informed and able to understand the consequences, benefits and risks of treatment, is given treatment options where possible and is offered the opportunity to access support from a trusted person in making that decision (free of undue influence; see Section 2: Supported decision-making)
- second opinions are free of conflict of interest and bias
- care and treatment are proportionate and tailored to the person's circumstances (least restrictive approach)
- compulsory treatment applies only for as long as a person is 'mentally disordered' as defined in the Act and that compulsory treatment is the least restrictive alternative for that person (applying for the shortest time possible)
- given that the Mental Health Act places significant limits on people's human rights (autonomy and liberty), agencies, services and health practitioners apply the safeguards in this Act.

Introducing a process of regular review by an impartial authority or judicial body will require a change to the Mental Health Act. As feedback on the Mental Health Act has consistently supported such an initiative, it is likely to be considered in new mental health legislation.

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Aotearoa New Zealand signed the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention Against Torture) in 1989. Aotearoa New Zealand also signed the Optional Protocol to the Convention Against Torture in 2007, which requires the Aotearoa New Zealand government to have independent monitoring of places of detention (where people are held against their will) to ensure that those places are free of torture and other cruel or degrading treatment.

In Aotearoa New Zealand, the Ombudsman is responsible for monitoring mental health facilities for compliance with the Convention Against Torture. The Ombudsman has identified instances where the Convention Against Torture may be breached for some people under the current Mental Health Act. These people may include, for example, those spending excessive lengths of time in compulsory care or seclusion.

Aotearoa New Zealand has also been criticised for the ongoing use and high rates of seclusion in our mental health services. Such criticisms have come from the United Nations Working Group on Arbitrary Detention, the United Nations Disabilities Committee and local watchdog organisations, such as the Human Rights Commission and the Ombudsman. Several people told the Government Inquiry into Mental Health and Addiction that seclusion and restraint are overused in mental health inpatient units, especially for Māori and Pacific peoples, often with traumatising or retraumatising impacts.

For guidance on the use of seclusion and restraint under the Mental Health Act, see *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act*, 'Chapter 15.7.2. Use of restraint' (Ministry of Health 2020a).

Declaration on the Rights of Indigenous Peoples

The Declaration on the Rights of Indigenous Peoples (the Declaration) sets out the individual and collective rights of indigenous peoples, including the right to identity and the right to health, prohibits discrimination against indigenous peoples. It also:

> … promotes their full and effective participation in all matters that concern them and their right to remain distinct and to pursue their own visions of economic and social development (United Nations, 2007).

The United Nations General Assembly passed the Declaration in 2007 and Aotearoa New Zealand endorsed it in 2010. The Human Rights Commission recommends that 'government decisions and policy should take the principles of the United Nations Declaration on the Rights of Indigenous Peoples into consideration alongside the Treaty [of Waitangi]' (Human Rights Commission 2010).

Article 24 of the Declaration is particularly relevant to the development of new mental health legislation. Under Article 24(1), Māori have 'the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals'. Māori also have 'the right to access, without any discrimination, all social and health services'.

Under Article 24(2), Māori 'have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.' This right reinforces the rights in Te Tiriti o Waitangi and requires the government to address inequities in health between Māori and non-Māori. For further discussion, see: Ministry of Health (2020a, Chapter 1); Ministry of Health (2020b); and Waitangi Tribunal (2019).

Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (UNCROC) sets out rights that specifically apply to all children (up to the age of 18 years) in international law. Aotearoa New Zealand ratified the convention in 1993 and has an obligation to uphold its principles.

The UNCROC requires the government to make the best interests of the child the primary consideration in all decisions affecting them. It gives children: the right to protection from discrimination; the right to their own opinion and for that opinion to be heard; the right to be informed about and participate in achieving their rights; and the right to life.

The UNCROC also includes special measures to protect children who belong to marginalised groups. Aotearoa New Zealand should implement the UNCROC in the context of Te Tiriti o Waitangi, supporting the benefits of a child or young person belonging to whānau, hapū or iwi.

The Office of the Director of Mental Health and Addiction Services monitors district health boards and providers of health residential and inpatient services for their compliance with Article 37(c) of the UNCROC.

Article 37(c) states:

> Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of [their] age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with [their] family through correspondence and visits, save in exceptional circumstances …

Based on the overarching principles in Article 37(c), young people up to the age of 18 years who are detained under the Mental Health Act must be treated in a child and adolescent specialist service. If, however, no other treatment within the child and adolescent specialist services is available, a suitably mature 16- or 17-year-old can be referred to adult mental health services. If this form of care is the only solution, services must maintain the young person's:

- connection to their family, whānau, hapū and iwi through correspondence, visits and video conferencing
- access to appropriate therapeutic and recreational activities, educational needs and alternative specialist care.

While the Mental Health Act, including its rights and protections, applies to all people of any age, children and young people have some additional protections (contained in Part 8 of the Act). Throughout the young person's care under the Mental Health Act, a psychiatrist practising in the field of child psychiatry must, wherever practicable, conduct the assessment and take part in the review of the young person's condition.

Taking the least restrictive approach

Compulsory treatment does not mean that people lose their human rights. Rather, decisions about compulsory treatment require clinicians to balance an individual's rights against the need for coercive interventions as permitted under the Mental Health Act. To avoid unnecessarily infringing on people's human rights, they should provide compulsory treatment in a manner that is consistent with the NZBORA, the Code of Rights and Te Tiriti o Waitangi principles to the greatest extent possible, and in the least restrictive way.

Under Principle One, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Code of Ethics states that ‘Psychiatrists shall respect the humanity, dignity and autonomy of all patients’ (RANZCP 2018). This is consistent with the Code of Rights (Right 1 to be treated with respect and Right 3 to dignity and independence) and with the human rights affirmed in the CRPD.

Principle One of the RANZCP Code of Ethics also states:

> 1.3 Psychiatrists shall be especially mindful of respect for autonomy given their statutory role in treating a proportion of their patients compulsorily. Compulsory treatment may be justified where a less restrictive intervention cannot achieve safe and adequate care; its purpose is ultimately to promote and re-establish patients’ autonomy and welfare. (RANZCP 2018)

Section 2: Supported decision-making

Supported decision-making is a central concept in the CRPD, which requires state parties to ensure people have the support needed to, among other things, make decisions about their medical treatment (Article 12). The objective is to enable all people to exercise full legal capacity, no matter what their cognitive status (Snelling 2019).

Supported decision-making provides a mechanism to uphold Right 7 of the Code of Rights. Under this right, consumers of health and disability services have the right to make an informed choice and give informed consent about their medical treatment to the greatest extent possible, given their individual circumstances.

With supported decision-making, the decision-making process centres on the individual (*Snelling & Douglass, 2019*). It is notably different from:

- substitute decision-making, where someone else is given authority to make decisions about a person's treatment
- shared decision-making, which describes person-centred approaches where people and their treating team make decisions together about treatment (Horvat 2019).

A supported decision-making approach assumes that all adults (with limited exceptions) have some level of ability to make decisions but may need varying levels of support in their efforts to make a decision or to express their will and preferences (Douglass 2016). Supported decision-making focuses on practical ways of enhancing a person's capacity.

The ability to make decisions or take actions that others view as legally effective or valid is referred to as a person's capacity. Under Aotearoa New Zealand law, a person is generally considered to have capacity when they can: understand the information relevant to the task or decision involved; retain that information; use it or weigh it in the process of making a decision; and communicate their decision (Dawson 2019). Decision-making capacity is not something that a person either has or does not have. Whether or not someone has decision-making capacity may vary depending on the particular decision involved and may fluctuate over time.

A supported decision-making approach is consistent with the principles of 'active protection', 'partnership', 'tino rangatiratanga', 'options' and 'equity' under Te Tiriti o Waitangi.

Evidence

Supported decision-making is an area in which research is rapidly emerging. Some international studies have explored the use of supported decision-making in people with serious mental illness (Jeste et al 2018). These studies have focused on the need for, rather than the outcomes of, supported decision-making. They suggest that individuals and their caregivers see supported decision-making as an acceptable and potentially superior alternative to substituted decision-making. An evaluation of these studies found that supported decision-making has the potential to meaningfully improve the wellbeing and quality of life of people with serious mental illness (Jeste et al 2018).

Aotearoa New Zealand is beginning to consider how to implement supported decision-making, and the legal mechanisms to enable and/or enforce it. A literature review commissioned by the Office for Disability Issues explores current thinking, practice and research related to support for disabled people's exercise of their legal capacity, including supported decision-making (Mirfin-Veitch 2016).

The individuals and whānau who have lived experience of the Mental Health Act are another important source of evidence. They have consistently said they want to participate in decisions that affect them (Government Inquiry into Mental Health and Addiction 2018).

Supported decision-making under the Mental Health Act

Right 7(3) of the Code of Rights states, 'Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.' In circumstances where there are reasonable grounds to believe a person is not competent to make informed choices and give informed consent, Right 7(4) of the Code of Rights includes that services should take reasonable steps to find out the views of the consumer and, if they still cannot establish what those views are, they should take into account the views of other suitable people interested in the welfare of the person.

The RANZCP Code of Ethics recognises the need to 'support the decision-making of a patient with impaired capacity so that, where possible, a decision can be validly made' (RANZCP 2018, Principle 5.6). The Code of Ethics also requires RANZCP members to 'respect the rights, will and preferences of the patient, and take into account any advance directive' when seeking consent from a substitute decision-maker (RANZCP 2018, Principle 5.7).

In the context of the Mental Health Act, supported decision-making should be seen as an attempt to provide care in the least restrictive way by promoting the self-determination and tino rangatiratanga of an individual with impaired decision-making capacity.

Supported decision-making is intended to facilitate greater involvement of individuals in making key clinical decisions that affect them and uphold respect for the person's rights and autonomy. This means considering and accommodating, as far as possible within the constraints of the Mental Health Act, the person's will and preferences (either stated at the time or previously expressed).

Using supported decision-making principles when applying the Mental Health Act provides mental health professionals with the opportunity to build relationships and trust with service users and their whānau, families and principal caregivers and to potentially reduce the use of coercive practice. It is also consistent with human rights and recovery approaches.

Central to the use of supported decision-making is providing patients with meaningful choices about treatment. For example, if a person has consistently rejected a particular treatment option, even at times when their mental state has been optimum, mental health professionals should respect this choice as far as possible (taking into account immediate safety concerns for that person) and the options discussed with the person, ideally with the support of someone they trust.

Some practical ways of bolstering a person's capacity to determine and communicate a choice are to:

- use communication aids (for example, list options on a piece of paper with the person, including risks and benefits, and allow adequate time for the person to consider and discuss the options, including their concerns and preferences)
- develop advance directives or a joint crisis plan
- involve informal supporters such as one or more trusted whānau or family members, friends or peer support people.

Advance directives and care plans

Right 7(5) of the Code of Rights states, 'Every consumer may use an advance directive in accordance with the common law'. An advance directive, also sometimes known as a Mental Health Advance Preference Statement or MAP,[2] is a written or oral directive or instruction in which a person tells health professionals about specific kinds of treatment that they would or would not want no matter how sick they are. The person may also specify who they wish to have, or not have, involved in their care.

A person makes an advance directive while they are well. It becomes effective only when the person loses the capacity to make their own choices.

Similarly, advance care plans set out how a person wants doctors to manage their care. The patient can modify or revoke either an advance directive or an advance care plan at any time, while they still have capacity.

We encourage clinicians to offer all patients the opportunity to create an advance directive and care plan as part of recovery and relapse prevention planning (see 'Recovery planning' below). In discussing an advance directive, clinicians gain the opportunity to understand what is important to a patient, and what they do and do not want to happen if a future episode of illness affects their decision-making capacity. During this process, we encourage giving the individual concerned the option to involve someone of their choice who can help speak to their needs (such as one or more family or whānau members, or a kaumātua, priest, principal caregiver or friend).

Advance directives and care plans are not legally binding, in that they do not take precedence over decisions made under the Mental Health Act. However, this does not mean that mental health professionals can ignore other parts of the advance directive. The Code of Rights requires that services treat people with respect, which includes listening to and following the person's preferences as much as possible.

The RANZCP Code of Ethics states that psychiatrists shall take into account any advance directive a patient has in place. This includes patients who are subject to the Mental Health Act. Some evidence indicates that advance directives can reduce the need for compulsion (Khazaal et al 2014).

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[2] Southern DHB in collaboration with the University of Auckland has developed and trialled this new advance directive tool. See **https://www.southernhealth.nz/getting-help-you-need/mental-health-and-addictions/mental-health-advance-preferences-statement**

Recovery planning

The Ministry of Health requires clinicians to regularly engage in recovery planning with every compulsory patient. This should be best practice for all patients who are being discharged or transferred to another service and is a core part of recovery-oriented practice. Recovery plans help people to better manage their own condition and to achieve positive mental health and wellbeing outcomes (Nicaise et al 2013).

The requirements of the Mental Health Act support recovery-oriented practice in relation to compulsory patients by promoting least restrictive care and directing services to consult family and whānau.

Recovery planning in the framework of supported decision-making should take a person-centred approach in which the plan is a collaboration between the patient and the clinician. A recovery plan needs to be holistic and meaningful, centring on the patient. Ideally, the person concerned would develop the plan, with support from their clinician and their whānau or family (see Ministry of Health 2020a, Chapter 5). As part of their recovery plans, mental health professionals should encourage patients to develop advance directives (see 'Advance directives and care plans' above).

For further discussion on the concept of recovery, see: RANZCP. 2016. Recovery and the psychiatrist. URL: **https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/recovery-and-the-psychiatrist** (accessed 2 August 2020).

Recovery plans should include discussion and planning for the patient's transitions between different parts of specialist services (for example, between inpatient and community services) and across services (for example, from specialist to primary care).

Evidence shows that improvements in the quality of people's mental health transitions can improve efficiencies in hospital resource use, improve consumer satisfaction and rates of recovery, and increase the person's resilience (Carswell and Pashkov 2018). A report by the Office of the Auditor-General found significant deficiencies in the way that people transition through mental health and addiction services (Controller and Auditor-General 2017).

Transition planning aims to:

- match service provision as closely as possible to the needs of individuals and have the most appropriate services deliver care
- make individuals and their whānau and families the key decision-makers about the services they receive
- deliver care across a dynamic continuum of health care services at specialist and primary levels and make decisions based on the needs and wishes of individuals and their whānau and families (not on service boundaries).

A person's right to a support person

Right 8 of the Code of Rights states, 'Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised, or another consumer's rights may be unreasonably infringed.' In addition, section 9(2)(d) of the Mental Health Act requires a support person to be present when a mental health professional is explaining the purpose of assessment to a proposed patient.

In a supported decision-making approach, people may call on one or more trusted support people to help them make a decision. In the context of the Mental Health Act, this would be the 'principal caregiver' (the friend, whānau or family member who is 'most evidently and directly concerned with the oversight' of the person's care and welfare – section 2).Mental health professionals should encourage patients to include their principal caregiver and any other natural supports when it comes to decision-making, such as whānau, family, friends, kaumātua or kuia.

A support person who the patient has previously identified may help represent the person's intentions and preferences about their treatment and recovery to members of the treating team. This right underlines the importance of asking about and documenting the patient's preferred support people, the extent of the support they would like from those people and the information to provide to those people.

References

Carswell P, Pashkov A. 2018. *Evidence-scoping Review – Service Transitions for Mental Health and Addiction: Report for the Health Quality & Safety Commission*. Auckland: Synergia. URL: **https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/Resources/Synergia-evidence-review-service-transitions.pdf** (accessed 2 August 2020).

Controller and Auditor-General (New Zealand). 2017. *Mental Health: Effectiveness of the planning to discharge people from hospital*. Wellington: Office of the Auditor-General. URL: **https://apo.org.au/node/92766** (accessed 2 August 2020).

Dawson J. 2015. Powers, rights and review procedures. In PDG Skegg, R Paterson (eds) *Health Law in New Zealand*. Wellington: Thomson Reuters.

Dawson J. 2019. General principles and sources of mental capacity law. In I Reuvecamp, J Dawson (eds) *Mental Capacity Law in New Zealand.* Wellington: Thomson Reuters.

Douglass A. 2016. *Mental Capacity: Updating New Zealand's law and practice.* Report for the New Zealand Law Foundation. Dunedin: New Zealand Law Foundation. URL: **http://www.lawfoundation.org.nz** (accessed 2 August 2020).

Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction.

Human Rights Commission. 2010. *Human Rights in New Zealand; Ngā Tika Tangata o Aotearoa*. Wellington: HRC.

Jeste DV, Eglit G, Palmer BW, et al. 2018. Supported decision making in serious mental illness. *Psychiatry* 81(1): 28–40.

Khazaal Y, Manghi R, Delahaye M, et al. 2014. Psychiatric advance directives, a possible way to overcome coercion and promote empowerment. *Frontiers in Public Health* 2(37): 1–5.

Ministry of Health. 2017. Submissions on the *Mental Health Act and Human Rights* discussion document – An analysis. URL: **https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment** (accessed 2 August 2020).

Ministry of Health. 2020a. *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

Ministry of Health. 2020b. *Whakamaua: Māori Health Action Plan 2020–2025*. Wellington: Ministry of Health.

Mirfin-Veitch B. 2016. *Exploring Article 12 of the United Nations Convention on the Rights of Persons with Disabilities: An integrative literature review.* Dunedin: Donald Beasley Institute.

Nicaise P, Lorant V, Dubois V. 2013. Psychiatric advance directives as a complex and multistage intervention: a realist systematic review. *Health and Social Care in the Community* 21(1): 1–14.

RANZCP. 2018. *Royal Australian and New Zealand College of Psychiatrists Code of Ethics.* Melbourne: Royal Australian and New Zealand College of Psychiatrists. URL: **https://www.ranzcp.org/files/about_us/code-of-ethics.aspx** (accessed 2 August 2020).

Horvat, L. 2019. *Partnering in Healthcare for Better Care and Outcomes*. Safer Care Victoria, State Government of Victoria, Melbourne.

Snelling J and Douglass A. 2019. *Legal capacity and supported decision-making*. In I Reuvecamp, J Dawson (eds) Mental Capacity Law in New Zealand. Wellington: Thomson Reuters.

Te Pou o te Whakaaro Nui and Ministry of Health. 2018. *Let's Get Real: Real skills for working with people and whānau with mental health and addiction needs*. Auckland: Te Pou o te Whakaaro Nui. URL: **https://www.tepou.co.nz/uploads/files/resource-assets/Let's%20get%20real%20-%20refresh%20-%20final.pdf** (accessed 2 August 2020).

United Nations. 2007. *United Nations adopts Declaration on Rights of Indigenous Peoples*. URL: **https://news.un.org/en/story/2007/09/231062-united-nations-adopts-declaration-rights-indigenous-peoples**.

Waitangi Tribunal. 2019. *Hauora: Report on stage one of the health services and outcomes kaupapa inquiry*. Wellington: Legislation Direct.

World Health Organization. 2019. *Mental Health, Disability and Human Rights. WHO QualityRights Core training – for all services and all people*. Course guide. Geneva: World Health Organization. URL: **https://apps.who.int/iris/bitstream/handle/10665/329546/9789241516709-eng.pdf** (accessed 2 August 2020).