The role of the MHA

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“This is not my home”

27 September 2016

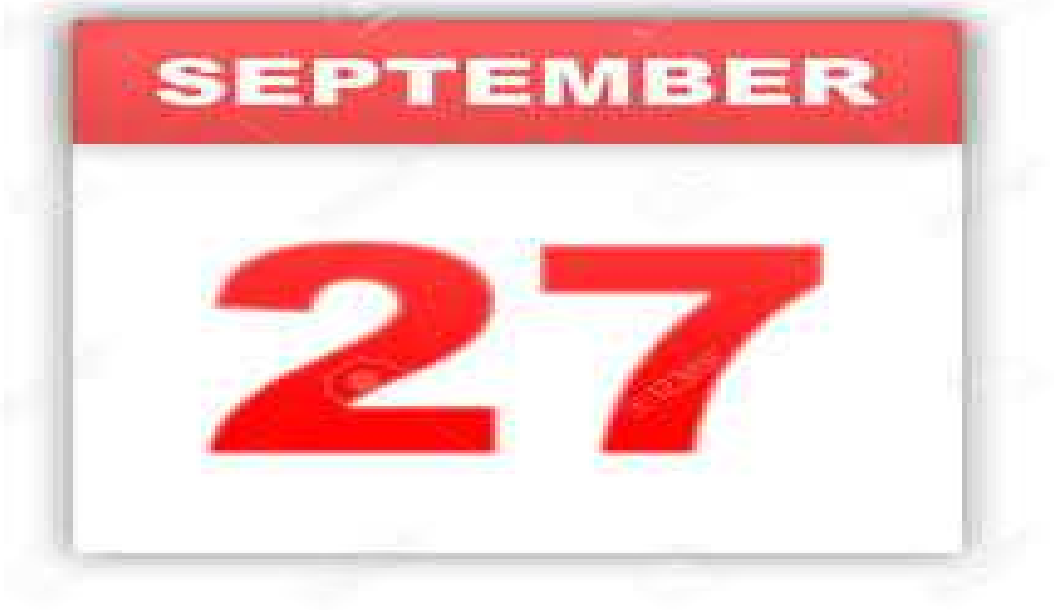
Overview

- When you can no longer decide – who decides then?
- What we are talking about today
- The MHA – a closer look

When you can no longer decide – who decides then?

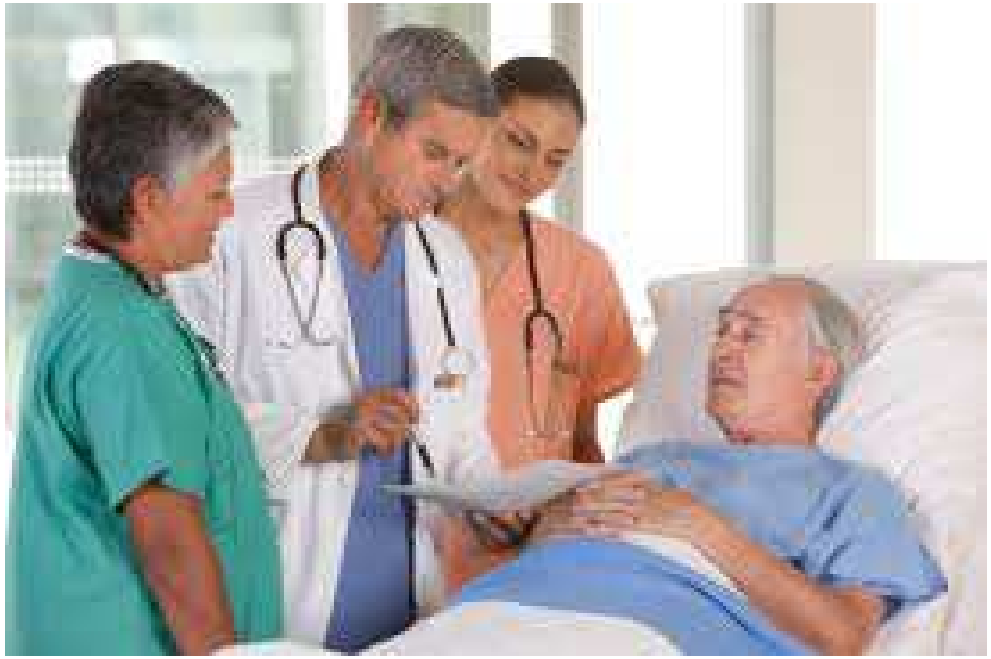
- You – by way of valid advance directive; or
- Someone you have appointed to act on your behalf – an Enduring Power of Attorney; or
- Those providing care - right 7(4) of the Code of Rights; or
- Persons appointed by the court by way of orders under the PPPR Act

What we are talking about today



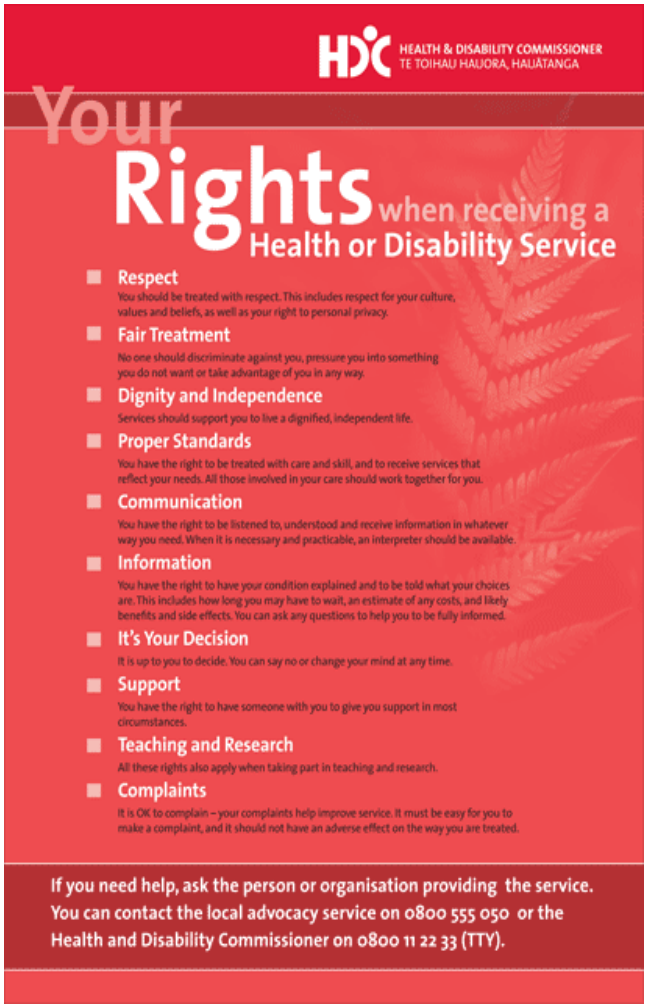
Where there is no advance directive and no one lawfully entitled to act on a person’s behalf

Right 7(4)



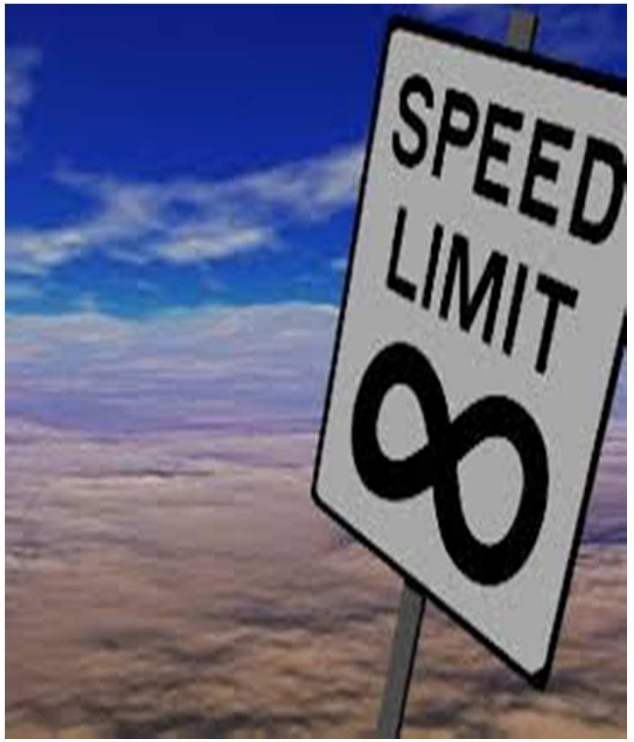
Right 7(4)

- Under Right 7(4) services may be provided if:
  - A consumer who is not competent to make an informed choice
    AND
  - There is no person entitled to consent AND:
    - Services are in the **best interests** of the consumer; and
    - Reasonable steps to ascertain **consumer's views**; and
    - **Views of consumer or other suitable person** taken into account



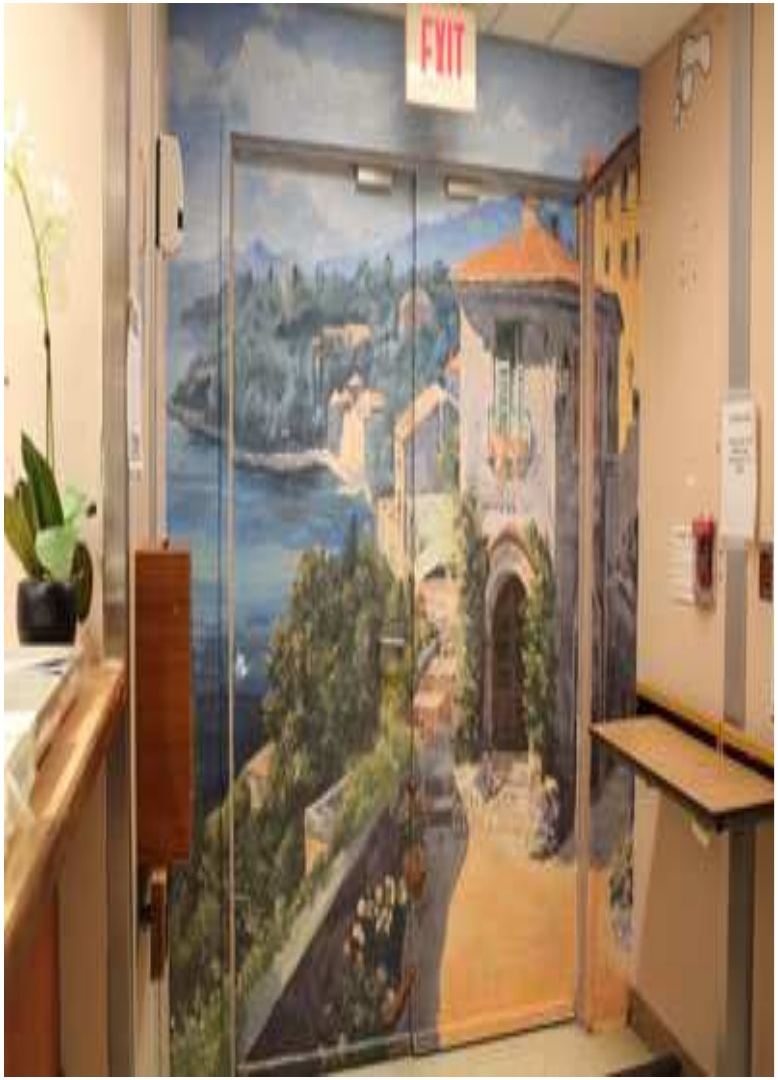
Limits of right 7(4)

- Uncertainty about capacity
- There is an EPOA/ welfare guardian
- Person is violently opposed to what is proposed
- Differing views amongst staff and/or family

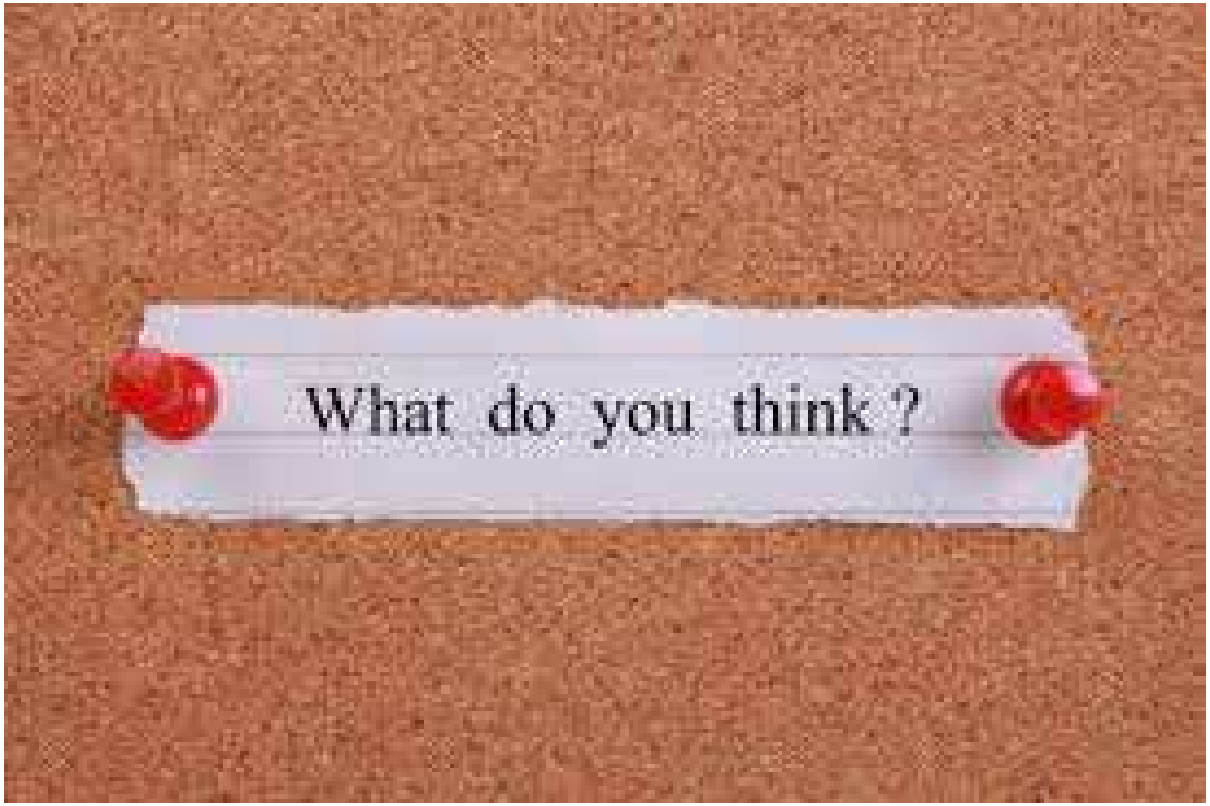


What about long-term detention?

- Right 7(4) broad enough to extend to long-term detention
- But – lack of appeal process/mechanism to ensure detention appropriate/ protection of rights

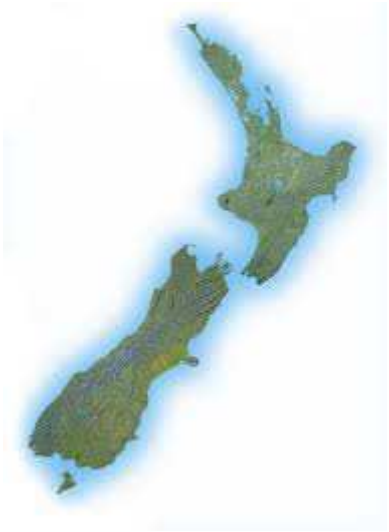


So should we use it for long-term detention?



In practice….

- Varies across the country
- Some NASCs/aged care providers require EPOA/Welfare Guardian

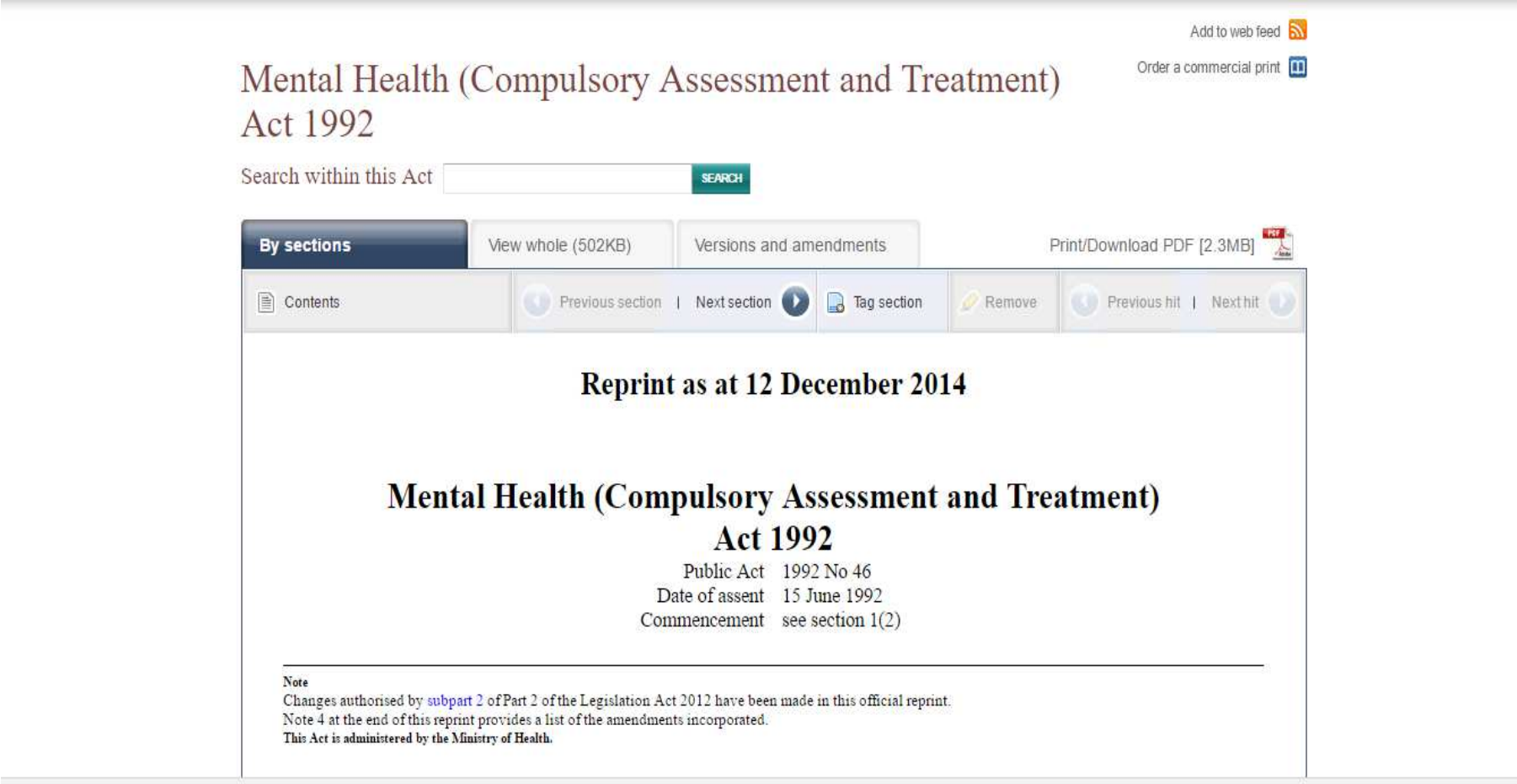


- Probably 1000s of people who lack capacity without EPOA/Welfare Guardian who are detained (whether in residential care or community)

Policy

- As a matter of policy, could require EPOA/Welfare Guardian/personal orders, but problematic:
  - Whose responsibility (i.e. who applies)?
  - Cost (of appointing EPOA/seeking court orders)
  - Delay (Family court – up to 26 weeks, maybe more)

What about the MHA – where does it fit in?



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Mental Health (Compulsory Assessment and Treatment) Act 1992

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Reprint as at 12 December 2014

Mental Health (Compulsory Assessment and Treatment) Act 1992

Public Act 1992 No 46
Date of assent 15 June 1992
Commencement see section 1(2)

Note
Changes authorised by subpart 2 of Part 2 of the Legislation Act 2012 have been made in this official reprint.
Note 4 at the end of this reprint provides a list of the amendments incorporated.
This Act is administered by the Ministry of Health.

Frequency of MHA use for dementia

Compulsory assessment and treatment

- If meet the definition of mentally disordered, can be subject to compulsory assessment and treatment under the MHA

Mental Disorder

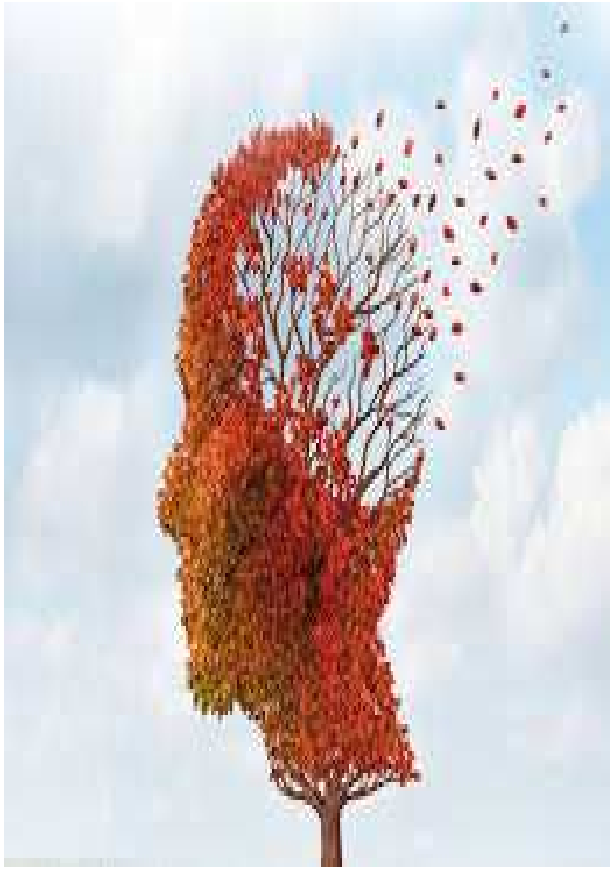
- `Mental disorder' in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception of volition or cognition, of such a degree that it –

  (a) poses a serious danger to the health or safety of a person or of others; or

  (b) Seriously diminishes the capacity of that person to take care of himself or herself

What about dementia?

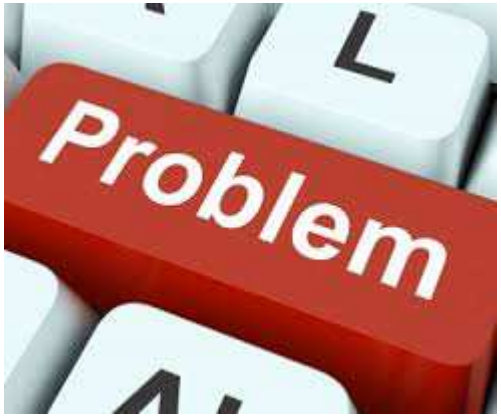
- If advanced, is likely to fall within the ambit of an abnormal state of mind characterised by disorder of cognition, and may well meet the risk aspect of the test, depending on the circumstances



Compulsory Treatment Orders

- Two types:
  - Community treatment order (to be preferred unless the court is satisfied the person cannot be treated as an outpatient)
  - Inpatient order (allowing detention in a specified hospital)

A couple of issues



- If subject to a community treatment order, this cannot require you to live in a particular place (just present to a specified place for treatment)
- If subject to an inpatient order, the patient needs to be an inpatient in a hospital certified to provide hospital mental health care (most residential care facilities are not)

Possible solution

- An inpatient can be placed on leave for up to 3 months, which can in certain circumstances, be extended to 6 months.
- Leave is on terms and conditions of responsible clinician. So could be that a patient resides at a residential care facility.

Benefits

- Person is safe and in an appropriate environment
- Person is not blocking an acute hospital bed
- Person has the benefit of the protective mechanisms of the MHA:
  - Review and appeal mechanisms
  - Patient rights
  - District Inspectors

But….

- It causes issues from a funding perspective, as the DHB will be paying for the patient's care out of its mental health budget rather than aged residential care

In conclusion

- The MHA is available if it isn’t appropriate to rely on right 7(4), and some urgency is required
- Should probably only be used as an interim measure pending court orders
- Is unlikely to be a long-term solution within the context of the current legal and regulatory framework

Questions?

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