mental health services, especially with regard to community-based and rehabilitative services, as well as preventive and promotional strategies.

Its focus on human rights issues and the delivery of timely, appropriate and quality treatment sees Fiji entering a new and progressive era of mental healthcare. The implementation of the Decree has provided valuable lessons regarding the need for consultation, awareness and training beforehand, as well as the need to plan, fund and resource this important process.

References

Singh, S., Chang, O., Funk, M., *et al* (2013) *WHO Profile on Mental Health in Development: Fiji*. World Health Organization.

World Health Organization (2008) *Western Pacific County Health Information Profiles 2008 Revision*. WHO.

MENTAL HEALTH LAW PROFILE

Mental health law in New Zealand

Ian Soosay[1] and Rob Kydd[2]

[1]Senior Lecturer, Department of Psychological Medicine, University of Auckland, New Zealand, email i.soosay@auckland.ac.nz

[2]Professor, Department of Psychological Medicine, University of Auckland, New Zealand, email r.kydd@auckland.ac.nz

New Zealand has an established history of mental health legislation that sits within a framework of human rights, disability and constitutional protections. We outline a brief history of mental health legislation in New Zealand since its inception as a modern state in 1840. The current legislation, the Mental Health (Compulsory Assessment and Treatment) Act 1992, defines mental disorder and the threshold for compulsory treatment. We describe its use in clinical practice and the wider legal and constitutional context which psychiatrists need to be aware of in their relationships with patients.

New Zealand has an established history of mental health legislation that sits within a framework of human rights, disability and constitutional protections.

The historical perspective

The modern state of New Zealand was established in 1840 with the signing of the Treaty of Waitangi between Maori tribal leaders and the British crown. By 1844, 'pauper lunatic asylums' had been set up in Wellington and Auckland, next to the local jails, to manage people with mental illnesses who were perceived to be dangerous. The colonial authorities introduced the first mental health legislation, the Lunatics Ordinance of 1846 (Brunton, 2005), which set out a framework for 'certification', whereby a person with a mental illness could be sent to a jail or a hospital.

In 1852, the New Zealand Constitution Act set up the New Zealand Parliament and the first elections were held the subsequent year. This also placed the responsibility for healthcare with provincial authorities, which went on to establish asylums in each province; these were modelled on the British asylum movement of the time. In the 1860s and 1870s, asylums were built in most provinces but a Joint Parliamentary Committee was established in 1871 to look into reported poor standards in some of the facilities. This resulted in the recommendations that large asylums should be run by medical superintendents and that a national inspectorate be established. All asylums were then centralised under the Lunatics Asylum Department in July 1876. The Mental Defectives Act came into force in 1911, which allowed voluntary admissions to hospital for the first time; it aimed to align the mental health system with the wider health system. The Social Security Act of 1938 provided for the costs of hospitalisation to be met through taxation and not patient fees. In 1969, Parliament passed the Mental Health Act, which has formed the basis of our current legislation, as amended in 1992.

The Mental Health (Compulsory Assessment and Treatment) Act 1992

Compulsory treatment of people with mental illness in New Zealand is governed by the Mental Health Act. The principles underpinning the Act are stated in the associated guidelines (Ministry of Health, 2012a):

> The Act is not a comprehensive framework for mental health treatment. It should instead be thought of as an entry point to services for people experiencing a mental illness which causes or may cause serious harm to themselves or others. Compulsory treatment under the Act provides an opportunity for a person experiencing a serious mental illness to begin to live well in the community and take self-ownership of their healthcare. This is promoted through a focus on regular collaborative consultation between compulsory patients and clinicians, and the statutory presumption in favour of minimally restrictive treatment in the community.

The Act defines mental disorder as 'an abnormal state of mind (whether of a continuous or an intermittent nature) characterised by delusions, or by disorders of mood or perception or volition or cognition'. However, no one can be subject to an assessment or treatment order based on mental disorder alone, but must also present risks to

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themselves or others, or be at risk of significant self-neglect. Political, religious or cultural beliefs, sexual preferences, criminal behaviour, intellectual disability and substance misuse are explicitly excluded as mental disorders.

Anyone can request a mental health assessment under the Act, supported by a recommendation by a registered medical practitioner, ideally his or her general practitioner. Mental health clinicians, usually registered nurses called duly appointed officers (DAOs), oversee the process (Ministry of Health, 2012b) and ensure that it complies with all legal requirements. People subject to assessment will have their rights under the Act explained to them before the interview, and they may have the support of a family member or a justice of the peace. Ideally, a specialist psychiatrist will conduct the clinical assessment. People found to meet the threshold of the Act are then subject to a period of assessment of up to 5 days, which can be extended by a further 14 days if needed. This assessment may be conducted in hospital or in the community and allows compulsory treatment. The guidelines (Ministry of Health, 2012a) state that:

> Despite the use of compulsion, clinicians must make efforts to obtain a patient's consent to treatment whenever possible. In all cases except emergency treatment, a clinician must attempt to obtain a patient's written consent to treatment.

That consent is said in the guidelines to be 'not the same concept as "informed consent" that is understood by clinicians generally':

> Informed consent should be obtained in the absence of coercion, whereas consent to compulsory treatment necessarily requires some degree of coercion to have already been used. 'Consent' in this context therefore refers to both informed consent and the lesser 'assent', which may be influenced by an element of coercion.

If a patient is unable to consent, a second opinion from another psychiatrist must be sought for any compulsory treatment. At the end of this period, the responsible treating consultant may apply to court for a 6-month treatment order, which may be in hospital or in the community. These courts are often held in mental health facilities such as hospitals. A judge can extend treatment orders for a further 6 months, after which a judicial review is required before an indefinite order can be granted. Anyone subject to compulsory treatment under the Mental Health Act has the option to appeal to an independent mental health tribunal at any point, and may re-appeal after a 3-month interval. They are also entitled to independent legal representation, paid for by the state through the legal aid programme.

The Act also sets out 11 core patient rights that have to be guaranteed to anyone in treatment. Right 1 concerns information: there is a right to information on patient rights, information on legal status, information on current treatment (including likely side-effects and the expected benefits) and information on rights to have a condition reviewed. Right 2 is patients' right to respect for their cultural identity, acknowledging different needs and beliefs. This includes the opportunity to speak in one's own language and to have a cultural assessment. There is a related right to an interpreter, competent in New Zealand sign language, for example (right 3). Right 4 is the right to appropriate treatment, of a professional standard. Patients treated in a psychiatric hospital must be given the same level of treatment and care as a patient being treated for a physical illness. Patients under the Act also have the right to be informed about the treatment (right 5), to refuse video-recording (right 6) and to ask an independent psychiatrist for a second opinion (right 7), as well as have the right to independent legal advice (right 8). The Act also protects the patient's right to maintain contact with family and the community, including the right to company (right 9), the right to have visitors and make telephone calls (right 10) and the right to receive and send mail (right 11). Lawyers with special responsibilities for safeguarding the Act, called district inspectors, are appointed to support people subject to the Act. They also visit and inspect hospitals, and can enquire into the management and treatment of patients.

The Mental Health Act makes provisions for five categories of 'special patients', whose actions have resulted in the involvement of the criminal justice system as defined by the Criminal Procedure (Mentally Impaired Persons) Act 2003. These include: people found unfit to stand trial; those found not guilty on account of their insanity; those sentenced to a combination of imprisonment and treatment; remand or sentenced prisoners who require treatment in a psychiatric hospital, ideally in a forensic in-patient unit; and those remanded for a court report pending trial or sentencing. Leave for special patients must be approved by the Ministry of Health and a change in status by the Minister.

An additional category, 'restricted patients', imposes similar restrictions on patients who may not necessarily have entered the mental health system by way of the criminal justice system, but who are deemed to present 'special difficulties because of the danger he or she poses to others', following an application by the Director of Mental Health to the District Court. The Regional Forensic Psychiatry Service manages restricted patients.

The wider legislative context

In addition to the Mental Health Act, practising psychiatrists need to have an understanding of other legislation that affects their relationships with their patients. The Bill of Rights Act 1990 sets out the fundamental freedoms of all New Zealanders, including the right to life and security of the person. Section 11 of that Act includes the right to refuse to undergo any medical treatment.

The Human Rights Act 1993 outlaws discrimination on a number of grounds (Ministry of Justice, 2004), including disability (incorporating mental illness), while New Zealand's ratification of the Convention on the Rights of Persons with Disabilities has further strengthened these rights.

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The Health and Disability Commissioners Act 1994 protects the rights of patients to be treated with respect, dignity and independence; to be free of discrimination; to have proper standards of care; to be fully informed; to make informed choices and to give informed consent; to have protection of privacy; and to have the right to receive support. Patients also have rights to privacy under the Privacy Act 1993, which governs access to medical notes and the sharing of patient information. If patients feel that these standards have not been maintained, they have access to legal redress (Human Rights Commission, 2010).

Summary

New Zealand has a history of mental health legislation dating back to its beginnings as a modern state. The current legislation allows compulsory assessment and treatment for people with mental disorders in hospital or the community in limited circumstances if there is a significant risk to the individual of harm or poor self-care, or a significant risk of harm to others. However, the core principle underlying the doctor–patient relationship is respect of the autonomy of the patient to make informed decisions and to consent to any treatment, and this is strongly supported by legislation, with oversight from a number of institutions. When compulsory treatment is deemed necessary, this is subject to judicial oversight and there are multiple opportunities for appeal. Importantly, patients who are subject to compulsory treatment continue to have their rights protected. There is an expectation that treatment will be delivered in the least restrictive environment, hence the extensive use of community orders, and that collaboration and consent to treatment are encouraged.

References

Brunton, W. (2005) The place of public inquiries in shaping New Zealand's national mental health policy 1858–1996. *Australia and New Zealand Health Policy*, **2**, 24.

Human Rights Commission (2010) *Making Complaints: A Guide for Mental Health Service Users*. HRC. Available at https://www.hrc.co.nz/your-rights/people-disabilities/our-work/making-complaints-guide-mental-health-service-users (accessed March 2016).

Ministry of Health (2012a) *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Available at http://www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992 (accessed March 2016).

Ministry of Health (2012b) *Guidelines for the Role and Function of Duly Authorised Officers: Mental Health (Compulsory Assessment and Treatment) Act 1992*. Available at http://www.health.govt.nz/publication/guidelines-role-and-function-duly-authorised-officers (accessed March 2016).

Ministry of Justice (2004) *A Guide to the Rights and Freedoms in the Bill of Rights Act for the Public Sector*. Available at http://www.justice.govt.nz/publications/publications-archived/2004/guidelines-on-the-new-zealand-bill-of-rights-act/publication (accessed March 2016).

SPECIAL PAPER

Child and adolescent mental health in sub-Saharan Africa: a perspective from clinicians and researchers

Jacqueline Phillips Owen,[1] Benjamin Baig,[2] Catherine Abbo[3] and Yonas Baheretibeb[4]

[1]Clinical Lecturer in Child and Adolescent Psychiatry, KEMRI–Wellcome Collaborative Programme, Kilifi, Kenya; Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK, email jacqueline.owen@kcl.ac.uk

[2]Clinical Lecturer in Child and Adolescent Psychiatry, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK

[3]Lecturer in Child and Adolescent Psychiatry, Department of Psychiatry, College of Health Sciences, Makerere University, Kampala, Uganda

[4]Assistant Professor in Psychiatry, Department of Psychiatry, University of Addis Ababa, Ethiopia

There is a widening mental health treatment gap for children and adolescents in sub-Saharan Africa. The region has few economic or human resources dedicated to the mental health of children and young people. The World Health Organization's Mental Health Gap Action Plan and the push for mental health to be included in the Millennium Development Goals have raised the profile of child mental health but comparatively few studies have estimated prevalence rates or assessed needs or tested interventions in African countries. In most countries there is no clear pathway to access treatment, especially in-patient facilities. This article considers these issues from clinical, educational and research perspectives.

There is a widening mental health treatment gap for children and adolescents in sub-Saharan Africa (SSA). This is compounded by: the occurrence of a major demographic transition; and the burden of communicable and non-communicable illness in the region (Global Burden of Disease Study, 2015) and its impact on psychopathology in children. In relation to the first point, improved childhood survival in resource-poor rural and urban areas has led to an increase in the proportion of children aged under 14 years, as reported by the United Nations Children's Fund (UNICEF, 2013). As is the case in most low- and middle-income countries (LMICs), SSA has few economic or human resources dedicated to the mental health of children and young people. The Mental Health Gap Action Plan produced by the World Health Organization

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