

LAGI TUIMAVAVE

**Culture Matters: The Mental Health (Compulsory Assessment and Treatment) Act 1992's journey to being culturally responsive.**

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## *I Introduction*

Pacific people often view mental illness as a form of spiritual possession emanating from the breach of a sacred covenant between a group of people or between this group of people and their gods.<sup>1</sup> This is an orthodox conceptualisation of the cause of the mental illness and it is believed that the only means to healing is to seek the input of traditional healers believed to have spiritual powers necessary to full restoration.<sup>2</sup> This belief is further sustained by the reality that once society knows that someone has been diagnosed as mentally ill, there is a strong likelihood that perceptions of the person will be conditioned by that knowledge and the prejudices which go with it to the extent that we no longer see the person with all of her or his abilities and positive attributes.<sup>3</sup> The danger here is that society will only see the reflection of its knowledge that the person is mentally ill.

Pacific people, people with disabilities and refugees (among others) are population groups that experience inequitable outcomes. Pacific communities experience poorer health outcomes in New Zealand and often present late, entering directly into acute services. Pacific health status remains unequal with non-Pacific people across almost all chronic and infectious diseases, including mental health and addiction.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT)A) sets up a system for the assessment and treatment of mentally disordered persons.<sup>4</sup> Its purpose is to redefine the circumstances and conditions under which compulsory psychiatric assessment and treatment may occur.<sup>5</sup> This is distinguishable from its predecessor<sup>6</sup> which was “paternalistic” and had “the protection of others in mind” therefore failing to ensure adequate protection of the rights of people with mental disorder”.<sup>7</sup>

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<sup>1</sup> Tamasailau Suaalii-Sauni and others “Exploration of Pacific perspectives of Pacific Models of Mental Health Service Delivery in New Zealand” (2009) 15(1) Pacific Health Dialog 18 at 19.

<sup>2</sup> At 19.

<sup>3</sup> Phil Fennell “Reviewed Work: Mental Illness: Prejudice, Discrimination and the Law by Tom Campbell and Chris Heginbotham” (1991) 18(4) Journal of Law and Society 505.

<sup>4</sup> Sylvia Bell and Warren Brookbanks *Mental Health Law in New Zealand* (2<sup>nd</sup> ed, Brookers Ltd, Wellington, 2005).

<sup>5</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, long title.

<sup>6</sup> Mental Health Act 1969.

<sup>7</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 14.

This paper sets out to renovate the MH(CAT)A because it is currently not culturally responsive to Pacific Islanders, a collection of people that currently makes up majority of its service users. This approach is based on the idea that there exist real disparities in the health outcomes of ethnic minorities compared with their mainstream counterparts. This has been acknowledged in the recent Mental Health and Addiction Workforce Action Plan, which emphasises Pacific people as a population group experiencing “inequitable outcomes”.<sup>8</sup> As a result the author hopes to bridge this disparity by critiquing the following elements of the MH(CAT)A. The first critique will be on the allocation of resources. The second critique involves looking at some elements of the definition of mental disorder. The third critique considers the consultation provision afforded to practitioners by section 7A. The fourth and final critique concerns section 65 which calls for respect for cultural identity.

Before conducting these critiques, the author will briefly discuss issues with professionals in the system and issues specific to Pacific Islanders. Subsequently, the author will address some of the important provisions of the MH(CAT)A for the purposes of this paper. These provisions include the definition of mental disorder, the compulsory assessment process and compulsory treatment orders, respect for cultural rights and rights of patients.

The final part of this paper discusses Pacific models of service delivery and introduces the Fonofale model to illustrate this.

## *II Issues with Professionals*

Developing the Pacific health workforce will significantly contribute to improving Pacific health outcomes. Pacific health and disability workers are needed because it creates connections with Pacific Island communities, enables personal understanding of Pacific issues and enhances Pacific cultural and language skills. A survey commissioned by the Mental Health Commission in 1999, found that with 2.5 percent of the mental health workforce, Pacific peoples were significantly underrepresented.<sup>9</sup> There are very few Pacific psychiatrists and clinical psychologists in practice or training, and Pacific mental health professionals are in such short supply that an increase in numbers must be a priority.<sup>10</sup> A possible explanation for this

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<sup>8</sup> Ministry of Health *Mental Health and Addiction Workforce Action Plan 2017–2021* (February 2017) at 3.

<sup>9</sup> Mental Health Commission *Pacific Mental Health Services and Workforce: Moving on the Blueprint* (2001).

<sup>10</sup> Ministry of Health *Pacific Health and Disability Workforce Development Plan* (November 2004) at 7.

shortage is that in an environment of increasing globalisation and international mobility, New Zealand is constantly competing with other countries for skilled workers.<sup>11</sup> Despite this explanation, New Zealand is not a homogeneous society and the ratio of its professionals should be comparable to that of its consumers. In summary, the following are some of the key areas in developing a sustainable Pacific mental health workforce:<sup>12</sup>

More Pacific peoples need to be recruited into the mental health workforce...and from all Pacific ethnic groups...Retention of workforce is a critical issue...Significant effort is needed to increase proportion of Pacific mental health workers with appropriate health qualifications...A pressing need exists to upskill the current Pacific mental health workforce so they are culturally and clinically competent...The role matua must be recognised as an integral part of mental health services for Pacific peoples...Successful progress towards increasing the number and skills of Pacific managers is essential for Pacific provider development and growing sector capacity.

In addition to the lack of Pacific Island professional staff members, responsible clinicians are procedurally problematic during mental health hearings by presenting information poorly, of poor quality or too late. This means that instead of mental health hearings dedicated to just the issues in contention, hearings become a forum where information is collected for counsel and patients.<sup>13</sup> This is a demeaning and belittling process for patients especially as aspects of their history are repeated which can exacerbate the shame that patients and their families already feel. The author therefore requests that cultural competency be introduced and deemed compulsory in the mainstream workforce that delivers services to Pacific peoples.<sup>14</sup> This ensures that mental health services provided recognises cultural differences and responds non-judgmentally in the way it delivers support and treatment on the basis of a consumer's age, gender, culture, sexual orientation, socioeconomic status, religious beliefs, psychiatric diagnosis and physical or other disability.

Section 70 of the MH(CAT)A enables a patient to ask a lawyer to advise on his or her rights as a patient or on any other matter. This section though does not provide an obligation on the

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<sup>11</sup> At 8.

<sup>12</sup> Mental Health Commission *Pacific Mental Health Services and Workforce: Moving on the Blueprint*, above n 9, at 11-12.

<sup>13</sup> Alexander Simpson "The Interpretation of New Zealand's Statutory Definition of Mental Disorder" (1998) 5 *Psychiatry, Psychology and Law* 147 at 148.

<sup>14</sup> Ministry of Health *Pacific Health and Disability Workforce Development Plan*, above n 10, at 16.

mental health authorities to provide a lawyer. This is problematic because there is no avenue for providing this service unlike in the Protection of Personal and Property Rights Act 1988<sup>15</sup> or the Criminal Justice Act 1985<sup>16</sup> where this is available. Where counsel for patients are available, they are occasionally ill prepared like the clinicians. Hearings, which under the 1969 Act had largely been formalities, turned into adversarial exchanges.<sup>17</sup> Counsel advocating for mentally disordered patients must bear in mind that they are intended to mitigate the vulnerability of their clients (patients), promote systematic change and eliminate barriers to social exclusion.<sup>18</sup> To achieve this, counsel shall diverge from being adversarial as they would usually in criminal and other civil settings in favour of therapeutic jurisprudence. Therapeutic jurisprudence plays down the culture of critique and adversarial dispute resolution in favour of practice models that emphasise the role of affective lawyering and the collaborative and emphatic dialogue.<sup>19</sup> Nevertheless, lawyers must at all times ensure that they are promoting social change for their clients (patients).

### *III Issues Specific to Pacific People*

It has been identified that Pacific people who migrate to New Zealand aged 18 years or over have significantly lower rates of mental illness than Pacific people born in New Zealand.<sup>20</sup> The consequence however of this is that the Pacific migrants are less likely to visit a mental health service than Pacific people born in New Zealand.<sup>21</sup> The *Te Rau Hinengaro* results indicate that younger Pacific people are more likely than older Pacific people to experience a mental disorder that is classified as serious. This is consistent with findings for the overall New Zealand population.<sup>22</sup> There were, however, some statistical differences between Pacific women and men in the prevalence of individual disorders. Pacific females had higher prevalence than Pacific males of certain anxiety disorders, major depression and eating

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<sup>15</sup> Section 65.

<sup>16</sup> Section 10.

<sup>17</sup> Alexander Simpson, above n 13, at 148.

<sup>18</sup> Stanley Stylianos and Vahe Kehyayan "Advocacy: Critical Component in a Comprehensive Mental Health System" (2012) 82(1) *American Journal of Orthopsychiatry* 115.

<sup>19</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 7.

<sup>20</sup> Ministry of Health *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review* (February 2008) at 26.

<sup>21</sup> At 26.

<sup>22</sup> Ministry of Health *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review*, above n 20, at 6.

disorders. Pacific males, on the other hand, had substantially higher prevalence of substance use disorders than Pacific females.<sup>23</sup>

Pacific peoples are more likely to face barriers to treatment than other ethnic groups in New Zealand due to language barriers and the shame of having a problem.<sup>24</sup> Traditionally, if a Pacific Island person got sick, it might be thought that a spirit was displeased with their behaviour or that of one of their relatives. It might be thought that they were suffering from hidden guilt or a secret wrongdoing or that another person had cursed them. To ameliorate this suffering, the sick person would go to a healer and would review their recent actions to try and discover what might have given offence. The patient would describe any symptoms to the healer who in return performs or directs proper directive measures.<sup>25</sup>

Another issue specific to Pacific people is that when a person is deemed to be mentally ill, even with the absence of official diagnosis, discrimination can come from all parts of the Pacific community, including the church, and stems from the notion that disabilities are linked to divine punishment. The church plays a major role in the life of most Pacific families and is often a centre of support, so it can become a source of distress or embarrassment for many disabled individuals and their families.<sup>26</sup>

#### *IV The MH(CAT)A*

##### *A Definition*

The MH(CAT)A's predecessor vested a detrimental amount of power in the hands of the psychiatrists to determine whether treatment was necessary based on their expertise.<sup>27</sup> The attitude was paternalistic and such legislation was purely based on a medical model. Under the Mental Health Act 1969, a person was considered mentally ill if he or she was:<sup>28</sup>

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<sup>23</sup> Ministry of Health *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review*, above n 20, at 6.

<sup>24</sup> Mauri Ora Associates for the Medical Council of New Zealand *Best health outcomes for Pacific peoples: Practice implications* (May 2010) at 33.

<sup>25</sup> At 29.

<sup>26</sup> Ministry of Health *Pacific Peoples' Experience of Disability: A paper for the Pacific Health and Disability Plan Review* (February 2008) at 24.

<sup>27</sup> Jonas Robitscher *The Powers of Psychiatry* (Houghton Mifflin, Boston, 1980).

<sup>28</sup> Section 2.

"Mentally disordered", in relation to any person, means suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:

- (a) Mentally ill-that is, requiring care and treatment for a mental illness:
- (b) Mentally infirm-that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:
- (c) Mentally subnormal-that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.

This definition reflects medical criteria and is self-defining because it implies that a person is said to be mentally ill because he or she required treatment for mental illness.<sup>29</sup> This caused concerns among counsel on civil libertarian grounds. Emanating from such concerns was a hybrid of statutory protection for patients and quality medical care.<sup>30</sup> This is reflected in the current definition of "mental disorder" which is based on phenomena as opposed to diagnosis:<sup>31</sup>

...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, of such a degree that it-

- a) Poses a serious danger to the health or safety of that person or of others; or
- b) Seriously diminishes the capacity of that person to take care of himself or herself.

In summary, in order to determine whether the concerned individual has a mental disorder, these four elements are required:<sup>32</sup>

- 1) An abnormal state of mind;
- 2) Whether of continuous or intermittent nature;
- 3) Characterised by delusions, disorders of mood or perception or volition or cognition;
- 4) Of the degree of seriousness that represents a danger to self or others or seriously diminishes capacity for self-care.

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<sup>29</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 14.

<sup>30</sup> At 15.

<sup>31</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.

<sup>32</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 149-150.



## *B Compulsory Assessment Process and Compulsory Treatment Orders*

The procedures are set out in Appendices 1 and 2.

Appendix 1 sets out the compulsory assessment and treatment process.<sup>33</sup> During this assessment period, the patient is entitled under section 16 of the MH(CAT)A to request a Family Court Judge to review his or her condition while the assessment process is in progress. Where the Judge grants the request, the assessment and treatment process comes to an end and the patient is discharged.<sup>34</sup> If the request is dismissed, the assessment and treatment process continues. The first request for review is always granted, but any subsequent requests for review can be refused where evidence show that the patient's condition has not made any progress since the first review.<sup>35</sup>

Appendix 2 sets out the process for making compulsory treatment orders.<sup>36</sup> There are three possible results at the end of this process. Depending on the order sought by the responsible clinician in his or her application, the patient will either be subjected to an inpatient compulsory treatment order,<sup>37</sup> a community compulsory treatment order,<sup>38</sup> or the application is dismissed if the Judge is satisfied on evidence that the patient is not mentally disordered. The latter is rare though.

## *C Respect for Cultural Rights*

### *1 Section 5 Powers to be exercised with proper respect for cultural identity and personal beliefs*

This provision encourages the involvement of family/whānau especially where this relationship is beneficial to the wellbeing of the patient.<sup>39</sup> It recognises that power must be exercised with

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<sup>33</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (November 2012) at 31.

<sup>34</sup> At 38.

<sup>35</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 16(1C).

<sup>36</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 41.

<sup>37</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 30.

<sup>38</sup> Section 29.

<sup>39</sup> Section 5(2)(a).

respect for the patient’s culture, language and beliefs.<sup>40</sup> This involvement therefore must be present as early as possible and during the compulsory assessment and treatment phase. Family/whānau are encouraged to update the responsible clinician or the responsible treatment team about the patient’s history and any changes when on leave or with family/whānau members.<sup>41</sup>

Section 5(2)(c) of the MH(CAT)A requires ‘proper respect for the person’s cultural and ethnic identity, language, and religious or ethical beliefs’. This is further affirmed in the MH(CAT)A which states that “every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5”.<sup>42</sup> This conveniently has the backing of the Code of Health and Disability Services Consumers’ Rights Regulation 1996 (the Code of Rights).<sup>43</sup>

## *2 Section 6 Interpreters to be provided*

This provision of the MH(CAT)A<sup>44</sup> requires a court, tribunal, or person exercising any power under the MH(CAT)A to ensure that an interpreter is provided for a patient, if practicable, if the first or preferred language of the patient is a language other than English. In practice, this provision means that the wishes of the patient should be sought, particularly prior to any court or tribunal proceeding.<sup>45</sup> People are entitled to choose to communicate in another language and the interpreter appointed must as far as reasonably practicable be competent.<sup>46</sup>

## *3 Section 7A Medical practitioner or responsible clinician to consult*

This provision requires a medical practitioner or responsible clinician to consult with family/whānau during the compulsory assessment and treatment process unless it is not in the best interests of the patient or proposed patient, or it is not reasonably practicable.<sup>47</sup> Consultation may require disclosing a patient’s or proposed patient’s personal and health

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<sup>40</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 17.

<sup>41</sup> At 17.

<sup>42</sup> Section 65.

<sup>43</sup> Code of Health and Disability Services Consumers’ Rights Regulation 1996, Right 1(3).

<sup>44</sup> Section 6(2); Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 18.

<sup>45</sup> At 18.

<sup>46</sup> At 18.

<sup>47</sup> At 21.

information to family/whānau.<sup>48</sup> Disclosure of information for the sole purpose of consulting under this provision is not a breach of the Privacy Act or Health Information Privacy Code.<sup>49</sup> The patient must nevertheless understand what the consultation process is about and the degree to which information will be shared.<sup>50</sup>

Consultation with family/whānau will not apply where the practitioner has “reasonable grounds” to decide that this is “not reasonably practicable” or it “is not in the best interests” of the patient or proposed patient concerned.<sup>51</sup> The responsible clinician “must consult” the patient or proposed patient when deciding whether it would be in the said patient or proposed patient’s “best interest” to consult with his or her family/whānau.<sup>52</sup>

#### *4 Part 6 Rights of patients*

Part 6 of the MH(CAT)A expressly and conveniently sets out a number rights available to patients. The single mandatory provision in this part entitles a person upon becoming a patient to receive a written statement of his or her rights as a patient.<sup>53</sup> This right comes into effect as soon as the concerned person comes into contact with the mental health system.<sup>54</sup> On one hand, the remaining provisions in this part are simply “entitlements”<sup>55</sup> while on the other hand, they are rights and rights imply duties which require corresponding obligations from the authorities and professionals who are responsible for the care of patients under the MH(CAT)A.<sup>56</sup>

Section 65 as briefly mentioned earlier is entitled respect for cultural identity, etc and sets out that every patient is entitled to be dealt with in a manner that accords with the spirit and intent of section 5. This section recognises that “different cultures have special needs and aspirations”

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<sup>48</sup> At 21.

<sup>49</sup> Privacy Act 1993, ss 7 and 53.

<sup>50</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 21.

<sup>51</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 7A(3).

<sup>52</sup> Section 7A(4).

<sup>53</sup> Section 64.

<sup>54</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 321.

<sup>55</sup> At 320.

<sup>56</sup> Human Rights Commission *Mental Health: Patient Rights and the Public Interest, a report to the Prime Minister by the Human Rights Commission on certain incidents at Kingseat and Carrington Hospitals in May 1991* (1992).

and such must be considered when a patient is compulsorily assessed and treated against his or her will.<sup>57</sup> In practice, satisfaction of this right arises in a multitude of circumstances.<sup>58</sup>

## *V Critique*

The current health system needs to be accountable to those who experience poorer health outcomes and who continue to be underserved by the system.<sup>59</sup> New Zealand's health system needs to do better for the population groups that do not enjoy the same health as New Zealanders as a whole. Mental illness "routinely brings with it membership of a wronged, insulted and excessively deprived class of persons".<sup>60</sup> This class of persons include Māori and Pacific peoples, some Asian subgroups, refugees, migrants and people with disabilities. To achieve this, the focus must be on removing the infrastructural, financial, physical and other barriers to delivering high-quality health services, both within the health sector and between it and other sectors. Sometimes, improving the health of these groups will involve tailoring services so they are available in more accessible places or at more suitable times, or are delivered in more culturally appropriate ways.<sup>61</sup> To address this, a critique will now follow so that the MH(CAT)A could be moulded in a culturally responsive way.

### *A. Resources in Community Care*

To deliver a holistic Pacific model of care requires access to resource, which in today's competitive society is difficult.<sup>62</sup> As an example of available resources, the total annual funding of mental health services specifically for Pacific peoples in 2005/06 was \$11 million.<sup>63</sup> Of this, 68 percent was allocated to community and residential services for all ages, 16 percent to child and youth services, 9 percent to family/carer and home-based support, and 5.5 percent to adult alcohol, drugs and problem gambling services. This funding provided for 116 full-time (worker) equivalents (FTEs) contracted among 19 Pacific providers of mental health services

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<sup>57</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 321.

<sup>58</sup> Family Law Service *Commentary: Mental Health (Compulsory Assessment and Treatment)/Compulsory Treatment of Patients* (online looseleaf ed, Lexis Nexis) at [9.83].

<sup>59</sup> Ministry of Health *New Zealand Health Strategy: Future Directions* (April 2016) at 25.

<sup>60</sup> Phil Fennell, above n 3.

<sup>61</sup> Ministry of Health *New Zealand Health Strategy: Future Directions*, above n 59, at 26.

<sup>62</sup> Tamasailau Suaalii-Sauni and others, above n 1, at 20.

<sup>63</sup> Ministry of Health *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review*, above n 20, at 24.

for Pacific peoples around New Zealand. The Pacific-specific child and youth mental health funding in 2005/06 was \$1.6 million, which is a 4 percent increase over the 2004/05 funding.<sup>64</sup> People with mild to moderate mental health disorders such as depression, anxiety and addictions are often treated in primary health care settings. Such treatment is funded through general mechanisms for funding primary health care, rather than explicit allocations for mental health services provided in primary health care settings.<sup>65</sup> This funding path has ongoing funding allocated of just over \$7 million.<sup>66</sup>

### *1 New Zealand*

In New Zealand, to enable the facilitation of a community treatment order as per section 29 of the MH(CAT)A, “every patient is entitled to medical treatment and other health care appropriate to his or her condition”.<sup>67</sup> Although a community treatment provider should not be able to plead lack of resources as justification for not providing satisfactory care, the statutory presumption of appropriate care does not translate into an obligation on public authorities such as community team providers to provide the necessary services.<sup>68</sup>

Public authorities can rely on the fact that resource consent as a relevant limitation is recognised in New Zealand. Firstly, this is set out in cl 3 of the Code of Rights which states that a provider will not be breaching the Code of Rights if it has taken reasonable action in the circumstances to give effect to the consumer’s rights. Although it is a sound argument, cl 3 is not a supreme provision. Instead, this must be balanced against other clauses such as the right to services of an appropriate standard. This balancing act is simply for the Judge to make but in remaining consistent with s 66 of the MH(CAT)A and with the Ministry of Health’s Action Plan, more resources should be allocated to community treatment care for Pacific people. The author believes that by doing this, health models will be translated into Pacific models of service delivery.<sup>69</sup>

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<sup>64</sup> Ministry of Health *Te Raukura: Mental Health and Alcohol and other drugs: Improving Outcomes for Children and Youth* (December 2007) at 6.

<sup>65</sup> Ministry of Health *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review*, above n 20, at 24.

<sup>66</sup> Ministry of Health *The Annual Report 2005/06 including The health and Independent Report: Annual Report for the year ended 30 June 2006: Director-General of Health’s Annual Report on the State of Public Health 2006* (October 2006).

<sup>67</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 66.

<sup>68</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 168-169.

<sup>69</sup> Tamasailau Suaalii-Sauni and others, above n 1, at 25.

Public authorities can also rely on the New Zealand Public Health and Disability Services Act 2002 (NZPHDSA) which states that the objectives set out in section 3(1) can only be pursued “to the extent that they are reasonably achievable within the funding provided”.<sup>70</sup> However the NZPHDSA goes on to state that “nothing in this Act entitles a person to preferential access to services on the basis of race”.<sup>71</sup> This reference to “a person” explicitly excludes an individual but it arguably does not exclude a group of people. If the Ministry of Health’s Action Plan 2017-2021 aims to address the reality that “Pacific health status remains unequal with non-Pacific people” across mental health and other diseases, then this group of Pacific people with mental disorder should be entitled to special treatment.<sup>72</sup> Currently, the rate of Pacific adults experiencing relatively high rates of psychological distress is 1.6 times more likely than other adults.<sup>73</sup> This group of Pacific adults deserves special treatment in the form of more resources in order for them to receive the appropriate care they deserve.

Although judges are reluctant to interfere with clinical decisions that impact on resource allocation,<sup>74</sup> limited resources can lead to patients being inadequately supervised, not complying with their medications and can eventually lead to relapses into acute illnesses.<sup>75</sup> Alternatively, in Auckland, lack of resources resulted in some areas, especially Auckland, having major shortages of acute beds which is a reflection of a stretched mental health service in New Zealand.<sup>76</sup> Nevertheless, article 6 of the Declaration on the Rights of Disabled Persons recognises that disabled persons have the right to medical, psychological and functional treatment and other services which will enable them to develop their capabilities and skills to the maximum as well as the right not to be subjected to more restrictive conditions of residence than necessary. Looking at comparable jurisdictions may assist the author with a solution.

## 2. *United Kingdom*

Community treatment care does not exist in the United Kingdom because it was considered that compulsory assessment and treatment should only be implemented if the patient is sick

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<sup>70</sup> New Zealand Public Health and Disability Services Act 2002, s 3(2).

<sup>71</sup> Section 3(3).

<sup>72</sup> Ministry of Health *Mental Health and Addiction Workforce Action Plan 2017–2021*, above n 8, at 3.

<sup>73</sup> At 4.

<sup>74</sup> *Northland Health Ltd v Shortland* [1998] 1 NZLR 433.

<sup>75</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 175.

<sup>76</sup> Alexander Simpson, above n 13, at 148.

enough to require hospitalisation.<sup>77</sup> The United Kingdom courts similarly with the New Zealand courts, refrain from interfering with decisions about resource allocation. This is illustrated in the English Court of Appeal case where an appeal by a health authority for refusing to fund further treatment was upheld.<sup>78</sup> However, in 1997, the court ruled that where there is an inadequacy of resources, the issue is for Parliament to address.<sup>79</sup>

Parliamentary supremacy and separation of powers are constitutional principles that are still well and alive in New Zealand. The author is therefore favourable towards the United Kingdom position because New Zealand Parliamentarians are democratically elected and are equipped with the tools for this task. To vest too much power in the court may result in the courts acting *ultra vires*.

### *3 United States*

The United States maintains a position that it is not discriminatory to hold patients who are mentally disordered in institutions as opposed to community treatment care simply because it is dependent on the available resources and the needs of other people with mental disabilities.<sup>80</sup> Evidently, allocation of resource in the United States rests on a balancing exercise of which patient or patients with mental disabilities require the resources more.

### *B Mental Disorder Definition*

Mental disorder is defined in the earlier part of this paper. Judge Keane in his judgment declares this definition as “more precise and exacting”<sup>81</sup> than the 1969 Act and involves a shift in emphasis from the idea of care and protection to the notion of dangerousness as an indicator of mental disorder. In all assessments, there must be a link between the abnormal state of mind and the personal or public interest.<sup>82</sup> Although the wording is in ordinary use, the definition nonetheless presents apprehensions that must be mitigated in order for the MH(CAT)A to be culturally responsive.

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<sup>77</sup> Mental Health Act 1983 (UK).

<sup>78</sup> *R v Cambridge District Health Authority, ex p B* [1995] 2 All ER 129.

<sup>79</sup> *R v East Sussex County Council, ex p Beth Tandy* [1997] EWCA Civ 2278.

<sup>80</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 172.

<sup>81</sup> *Re C [mental health]* [1993] NZFLR 877.

<sup>82</sup> Sylvia Bell and Warren Brookbanks, above n 4.

## *1 Abnormal state of mind*

The first concern, is the definition of ‘abnormal state of mind’. Firstly, the meaning of ‘abnormal’. The usage of this term is problematic because like the term normal, it is constructed in a way that creates problems for the mentally disordered patient.<sup>83</sup> Looking at it from the term ‘norm’ it implies that as a majority, we must or should somehow be part of the norm. Norm comes with the concept of deviation or extremes and thus when we think of bodies, in a society where the concept of the norm is operative, disabled persons will be thought of as deviants.<sup>84</sup> The downside of this implication is that it adds to the stigma that is already inherent in this mental disorder label. In the mental health space, stereotypes exist about Pacific consumer capability levels or lack thereof, which lead to unfair discrimination.<sup>85</sup> These stereotypes add to this notion of abnormal. Pacific consumers with mental disorder, suffer from these many forms of abnormalities including limited career opportunities which consequently, create or perpetuate barriers to recovery.

Therefore, the concern is in defining ‘abnormal’ as no current definition exists in the MH(CAT)A. To define it subjectively would mean looking at the “normal position of the individual concerned” while an objective definition compares the concerned individual’s thoughts and behaviours with that of the wider community.<sup>86</sup> The author objects to the objective approach because it can lead to a danger of “cultural and class bias against which the consensus of a culturally and economically homogeneous medical profession is no defence”.<sup>87</sup> Given that there is a concern about the number of Pacific people and other ethnicities in the mental health system, this “should be cause for concern”.<sup>88</sup>

The author suggests that either Judge McElrea’s definition be considered going forward.<sup>89</sup>

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<sup>83</sup> Lennard Davis *Enforcing Normalcy: Disability, Deafness and the Body* (Verson, New York, 1995) at 24.

<sup>84</sup> At 29.

<sup>85</sup> Tamasailau Suaalii-Sauni and others, above n 1, at 22.

<sup>86</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 17.

<sup>87</sup> Marti Loring and Brian Powell “Gender, Race, and DSM-III: A Study of the Objectivity of Psychiatric Diagnostic Behavior” (1988) 29 *Journal of Health and Social Behavior* 1.

<sup>88</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 18.

<sup>89</sup> *Police v Tetai* [1993] DCR 600.



In ordinary parlance, an “ordinary state of mind” includes an unusual condition of the mind, and there is no reason to say that it must be temporary or otherwise or amenable to treatment (psychiatric or otherwise). In my view the ordinary use of the words requires that mental retardation be regarded as an abnormal state of mind...

or the following provision from the Human Rights Act 1993:<sup>90</sup>

...any other loss or abnormality of psychological, physiological, or anatomical structure or function.

Proceeding with one of these definitions ensures that miscarriage of justice towards Pacific Island mentally ill patients is avoided. It encourages clinicians to not measure whether, taken as a whole, a person has an objectively abnormal state of mind compared with that of the average person, but whether any phenomena indicating an abnormal state of mind are present.<sup>91</sup> This averts reliance on diagnosis which is an attempt to identify an illness, simply based on the presence of patterns of psychopathological abnormalities, basis of the cause, time course and outcome of the disorder.<sup>92</sup>

## 2 *Continuous or intermittent*

This element of the definition of mental disorder “reflects an allowance for a fluctuating intensity of the phenomena characterising an abnormal state of mind.”<sup>93</sup> Early tribunal decisions suggest that at times patients subject to compulsory orders should not necessarily be discharged simply because the order was in abeyance, provided there was sound evidence that the disorder would return.<sup>94</sup> This is reflected in the case of *In the Matter of T* where the Tribunal rejected:<sup>95</sup>

...any argument that it must only consider the applicant's "present state", i.e. his presentation on the day of the hearing. A patient's present state is inextricably interwoven with his or her past longitudinal psychiatric history.

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<sup>90</sup> Section 21(1)(h)(v).

<sup>91</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 4.

<sup>92</sup> John Dawson “Psychopathology and Civil Commitment Criteria” (1996) 4 *Medical Law Review* 62.

<sup>93</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 4.

<sup>94</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 19.

<sup>95</sup> [1994] NZFLR 946 at 19.

It was further held that where it is evident that without careful management a patient could suffer relapse of a disorder that could endanger themselves or others then even if there is no evidence of danger at the time assessment, the MH(CAT)A could be invoked.<sup>96</sup>

This Ministry of Health Guidelines indicate that compulsory treatment may be appropriate in some cases for a person who appears to currently be well if the person has previously demonstrated the following:<sup>97</sup>

...repeated or prolonged episodes of illness, severe consequences during phases of illness, such as severe violence to self or others, early loss of insight during an episode of illness, with a pattern of failing to be able to take the necessary steps to halt the development of illness, changeable insight into the nature of their mental illness that results in an inability to maintain a consistent decision to seek appropriate treatment.

Ostensibly, interventions in these circumstances is justified as good clinical practice since it prevents relapse.<sup>98</sup> Regardless of whether this is good clinical practice or not, clinicians must nevertheless treat each person as an individual. Pacific Islanders are already subject to excessive stereotypes that sometimes, what has been decided for one mentally disordered patient is more than likely to be decided for subsequent patients. This is a disadvantage for patients that suffer mental illness as a one-off. They fear being labelled mentally ill because they face double discrimination because of being service users and because of their ethnicity or cultural identity.<sup>99</sup>

### *3 Serious danger to the health or safety of the person or others*

The definition of “serious danger” requires more guidelines. In the decision of *Re JK [mental health]*, Ellis J held that serious danger should be equivalent to “causing serious physical injury” and the risk or behaviour would result in detention irrespective of whether or not the person was mentally ill, effectively importing a criminal standard.<sup>100</sup> This ruling though has

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<sup>96</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 19.

<sup>97</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 4.

<sup>98</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 20.

<sup>99</sup> Folole Esera “If a client is operating from a Samoan world view how can s/he be holistically and appropriate treated under the western medical model?” (LLM Dissertation, Victoria University of Wellington, 2001) at 46.

<sup>100</sup> [1994] NZFLR 678.

not been without criticism. This threshold has been condemned as “inappropriately high” as well as contributing to a “climate of uncertainty of the criteria and thresholds under which compulsory treatment could be ordered”.<sup>101</sup> Regardless of where the definition for serious danger comes from, it must be recognised that:<sup>102</sup>

...the rigid belief in the biomedical model and bias towards scientific health models by professionals in the New Zealand health system, and the over-riding acceptance of decisions made by those in authority, is such that people from other cultures, Samoans included, accept these attitudes and are beginning to lose faith in themselves.

Therefore the definition of serious danger must not be bias but must be understood by all consumers of the mental health service regardless of whether they are Pacific Islanders or not. Pacific people and others’ perspective of health must be fully understood by mental health services in New Zealand before subjecting them to standards set by European professionals, European judges and European models.

### *C Section 7A Consultation*

This provision was inserted on 1 April 2000 by the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999 as a response to official concerns to strengthen family/whanau involvement in the compulsory assessment and treatment process, enhance the contribution the family/whanau can make to the subsequent care, and assist in addressing concerns about information sharing and education about treatment options.<sup>103</sup> The term consultation is not defined in the MH(CAT)A but it must be recognised that when engaging with Pacific Islanders, some do not maintain eye contact when in conversation with others while others are silent and non-responsive just to name a few. This is not a rude gesture but is instead an act of respect which can often be misinterpreted as a sign of rebellion, withdrawn and introverted.<sup>104</sup> If consultation is not conducted in a culturally appropriate manner,

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<sup>101</sup> Alexander Simpson, above n 13, at 148.

<sup>102</sup> Folole Esera “If a client is operating from a Samoan world view how can s/he be holistically and appropriate treated under the western medical model?”, above n 99, at 52.

<sup>103</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (April 2000) at 22.

<sup>104</sup> Folole Esera “If a client is operating from a Samoan world view how can s/he be holistically and appropriate treated under the western medical model?”, above n 99, at 48-49.

sentences can have unintended connotations, gestures can be misinterpreted and facial expressions can be misread.<sup>105</sup>

The omission of a definition of consultation from the interpretation section leaves the author feeling uncomfortable and anxious particularly because section 7A concerns weighing up the rights of the patient and his or her family. In a setting involving two or more counsel and a solicitor, consultation is defined as “seeking and giving advice, information and/or opinion”.<sup>106</sup> The Local Government Act 2002 sets out a consultative process whereby the local authority makes information “as widely available as is reasonably practicable” to the public and the public is given the opportunity to present its views:<sup>107</sup>

...in a manner that enables spoken (or New Zealand sign language) interaction between the person and the local authority or any representatives to whom an appropriate delegation has been made.

This process could be beneficial in a private confidential setting (whereby the wider public is not a party) for Pacific Island mentally disordered patients because the manner in which consultation is facilitated means that the opinion of the patient is respected and considered. It is an individualised approach as well as a safe environment for the patient to decide whether his or her family should be consulted by the practitioner.

In the case of *R v Irwin*, it was held that before the youth offender gives a statement to police officers, the youth has a right to consult a lawyer and/or adult who the youth wanted.<sup>108</sup> What this emphasizes is that, the patient like the youth in this case, is entitled to give advice, information and /or opinion to the practitioner before the practitioner makes a decision. This ensures clinicians give effect to prior competently expressed wishes. Consulting is a right that should be available to all patients especially those of Pacific Island descent because although the patient’s family can be an integral part of his or her wellbeing, the patient’s liberties should be given precedence.

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<sup>105</sup> Folole Esera “If a client is operating from a Samoan world view how can s/he be holistically and appropriate treated under the western medical model?”, above n 99, at 48.

<sup>106</sup> LexisNexis New Zealand *Butterworths New Zealand Law Dictionary* 7ed (online looseleaf ed, LexisNexis).

<sup>107</sup> Section 83.

<sup>108</sup> [1992] 3 NZLR 119.

Although the author argues that the patient's autonomy should be upheld, family is nevertheless the foundation of all Pacific affairs. For this purpose, one new provision should be added to section 7A as presented by Luamanuvao Winnie Laban MP in her amendment bill in 2009 which did not proceed past the first reading stage in Parliament. Ms Laban recommended the inclusion of a subsection that clarifies "the entitlements of the family or whanau once the practitioner has decided to consult them".<sup>109</sup> Including this ensures there is transparency in the process, it protects the practitioner but it also provides a black and white picture for family members as to what they are entitled to. This also guarantees that the relevant provisions of the Privacy Act 1993 and the Health Information Privacy Code are adhered to.

Under section 7A of the MH(CAT)A, the practitioner does not consult the family or whanau of the proposed patient or patient if the practitioner has reasonable grounds for deciding that consultation is not reasonably practicable or is not in the best interests of the proposed patient or patient.<sup>110</sup>

### *1 Best interests*

This standard makes an appearance in section 19 and clause 2 of the First Schedule of the MH(CAT)A. The interest of the patient or proposed patient trumps anyone else's interests. The tension that arises from using this test is that the patient or the proposed patient's best interests is weighed up against that of his or her family/whānau. Some Pacific patients may want family members to be involved in all aspects of their care and decision making however this varies across different families and cultures.<sup>111</sup> Seeing that the mentally disordered patient's family is afforded some form of rights in this section, it is essential that a definition of family is contained within the Act. The purpose for this is that Pacific Island cultures vary in what they classify as family especially so concerning a patient that is of Pacific Island and Pakeha descent. For some, family is not limited to relationships based on blood ties and may include:<sup>112</sup>

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<sup>109</sup> (17 March 2010) 661 NZPD 9585.

<sup>110</sup> Section 7A(3).

<sup>111</sup> Mauri Ora Associates for the Medical Council of New Zealand *Best health outcomes for Pacific peoples: Practice implications*, above n 24, at 28.

<sup>112</sup> Ministry of Health *Involving Families: Guidance Notes: Guidance for involving families and whanau of mental health consumer/tangata whai ora in care, assessment and treatment processes* (November 2000).

...relatives of the tangata whai ora (including a spouse or partner), a mixture of relatives, friends and others in a support network, only non-relatives of the tangata whai ora.

Tangata whai ora means the person who is the subject of care, assessment and treatment processes in mental health.<sup>113</sup> For this purpose and to avoid confusion, a definition of family is necessary and thus should be included in the interpretation section of the MH(CAT)A. Regardless of this definition of family, the author urges that the right of the tangata whai ora is recognised by ensuring their consent is given before the so-called family becomes involved. The author proposes the following three definitions that could potentially be included in the MH(CAT)A. The first defines family as “a consumer’s family or an extended family/group of people who are important to the consumer”.<sup>114</sup> The second defines family as:<sup>115</sup>

This may be a single person whanau, a nuclear person whanau, a large extended whanau or another group which may not have blood ties but lives as a cohesive unit.

The third and final definition defines family as:<sup>116</sup>

A collective of descendants of a common ancestor, usually of three to four generations and their partners who interact together on an ongoing basis.

It is the medical practitioner’s role to determine what is in the patient or proposed patient’s best interests and to do this, he or she is required to consider all relevant clinical or personal information.<sup>117</sup> Subsequently, the medical practitioner in deciding whether consulting the family/whānau is not in the best interests of the patient or proposed patient, must also consider several facts.<sup>118</sup>

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<sup>113</sup> Ministry of Health *Involving Families: Guidance Notes: Guidance for involving families and whanau of mental health consumer/tangata whai ora in care, assessment and treatment processes*, above n 112.

<sup>114</sup> Ministry of Health *The National Mental Health Standards* (June 1997).

<sup>115</sup> Public Health Commission *He matariki: A strategic plan for Maori public health: the Public Health Commission's advice to the Minister of Health, 1994-1995* (Public Health Commission, Wellington, 1995).

<sup>116</sup> Ministry of Health *Involving Families: Guidance Notes: Guidance for involving families and whanau of mental health consumer/tangata whai ora in care, assessment and treatment processes*, above n 112.

<sup>117</sup> Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*, above n 33, at 4.

<sup>118</sup> At 27.

## *2 Reasonably practicable*

The author's concern with this term is that it is measured objectively. This is not feasible in a Pacific community because every patient is different and must be assessed holistically. Therefore, the author recommends that this term calls for a case by case basis assessment because the Pacific Island is a heterogeneous society and their differences ought to be respected.

### *D Section 65 Respect for Cultural Identity etc.*

New Zealand is an ethnically diverse nation and requires more than just a bicultural approach to adequately address the range of issues faced by mental health professional staff. Although section 65 is an “unequivocal commitment to addressing” the mental health services’ lack of sensitivity to cultural matters involving Maori patients, such commitment must extend to Pacific Island mental health patients too.<sup>119</sup>

What has not yet been a topic for moot in relation to this provision is the question of culturally inappropriate assessment and treatment. Although the assessment period is relatively short (first period of assessment is five days,<sup>120</sup> and second period of assessment is fourteen days,<sup>121</sup>) and there is usually a high volume of potential mental health patients under the MH(CAT)A, this should not justify responsible clinicians from not adhering to the requirements of section 65.

Many Pacific Island cultures require clinicians to ask for permission before touching or examining them and to explain before a physical examination what they are about to do and why and to seek permission to proceed.<sup>122</sup> Explaining and discussing practices clearly and in advance will help put the patient at ease and to determine what is appropriate for each patient.<sup>123</sup> Clinicians must also comprehend that historically, Pacific people did not consider biological agents such as bacteria and viruses as the causes of disease but instead they believed that

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<sup>119</sup> Sylvia Bell and Warren Brookbanks, above n 4, at 322.

<sup>120</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 11.

<sup>121</sup> Section 13.

<sup>122</sup> Mauri Ora Associates for the Medical Council of New Zealand *Best health outcomes for Pacific peoples: Practice implications*, above n 24, at 26.

<sup>123</sup> At 27.

supernatural forces caused illness.<sup>124</sup> There is an element of victim blaming in this belief which can bring about shame in the patient and his or her family.<sup>125</sup> Anti-psychotic drugs, injections etc. are the Western means of curing illnesses while Pacific healers use plant medicine in the form of potion and applications instead. With these in mind, the responsible clinician and other professional staff must understand and appreciate these when assessing and treating the patient. It is crucial for clinicians to honestly outline their reasons for their diagnosis especially if the Pacific Island patient sincerely believes that his or her illness is due to supernatural forces, because it signifies hope in that the illness is curable if the patient cooperates. Clinicians must not challenge their beliefs because to do so would be depreciating their ancestors and cultural heritage, but must instead assist them to be as healthy as possible in a respectful way as opposed to being argumentative, condescending and patronising.<sup>126</sup> The author believes that the combination of the modern Western and Pacific medicines can help some Pacific Island mentally disorder patients better understand their conditions and be on their way to recovery.

## *VI Pacific Models of Service Delivery*

To be culturally responsive requires a Pacific service delivery model that is informed by Pacific models of health belief and exist in implicit rather than explicit forms. To develop clearer or specific articulations of Pacific models of service delivery, the first step for services is to develop written expositions (a theory) of how these models might be framed taking into equal account cultural, clinical, and service management issues.<sup>127</sup> The MH(CAT)A is based on a medicalised European model that simply believes that mental illness is treatable and curable if the right drugs are administered. What is problematic about this is that as shown by the medicalised model of suicide in Australia, clinicians believe that there is a likely suicide gene or some chemical imbalance in the brain that needs to be located and eliminated.<sup>128</sup> What is missing from such European models is the consideration of the social contexts of mental disorders from a Pacific perspective. Responsible clinicians and other professional staff are merely equipped with tools to look for illness and disease and to administer medical treatment. They are not equipped with the means to address social problems which can result in their

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<sup>124</sup> At 29.

<sup>125</sup> At 30.

<sup>126</sup> At 30.

<sup>127</sup> Tamasailau Suaalii-Sauni and others, above n 1, at 19.

<sup>128</sup> Colin Tatz “We need to move beyond the medical model to address Indigenous suicide” (10 August 2015) The Conversation <http://theconversation.com/we-need-to-move-beyond-the-medical-model-to-address-indigenous-suicide-44652>.



dealing with mentally disordered Pacific Islanders in isolation. What is further problematic is that using medicalised concepts to explain mental disorder emphasizes the intra-individual concomitants of psychiatric problems such as biological and psychological factors and as aforementioned, minimised the importance of the social context in which such problems arise.<sup>129</sup> By ascribing the causes of mental disorder to factors within individuals, European medicalised models direct attention away from adverse societal factors such as poverty, inequality, powerlessness and alienations and thus shield the existing socio-political system from criticism and reform.

The MH(CAT)A contains two provisions that explicitly states that cultural identity must be respected. This is unsatisfactory and inadequate considering that Pacific peoples currently make up 6.9 percent of the New Zealand population, and between 2001 and 2006 the Pacific peoples' ethnic group was the second fastest growing ethnic group in New Zealand.<sup>130</sup> Pacific peoples are diverse and heterogeneous – each Pacific nation has its own set of cultural beliefs, customs, languages, values and traditions. There are also differences within each Pacific community in New Zealand, particularly in relation to levels of acculturation, which may be reflected in variations in perceptions of mental health. However, there are underlying shared pan-Pacific socio-cultural approaches that allow a discussion of mental health from a Pacific perspective.<sup>131</sup>

The author therefore recommends that either the MH(CAT)A or the overall mental system needs to be revamped to take into account the important values and beliefs contained in the Fonofale model.

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<sup>129</sup> Iain Twaddle, Peter Roberto and Ladisa Quintanilla “Chamorro Perspectives on Mental Health Issues in Guam: Cross-Currents of Indigenous and Western Cultural Discourse” (2002/2003) 14 *South Pacific Journal of Psychology* 30 at 32.

<sup>130</sup> Ministry of Health *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review*, above n 20, at 2.

<sup>131</sup> At 2.

### *A The Fonofale Model*

The Fonofale model of health was developed to explain key features that Pacific peoples consider important for maintaining good health, and which are distinct from approaches to health within mainstream New Zealand culture.<sup>132</sup> This model utilises the metaphor of a Samoan meeting house to make the point that in order for the house to stand firm, its core structure must exist and hold together – from the foundation to the posts and roof.<sup>133</sup>

The roof signifies cultural values and beliefs that is the shelter of life. Culture is constantly evolving in New Zealand thus it includes New Zealand born Pacific peoples as well as Pacific peoples born and bred in their Island homes. What is significant is that there will be a mixture of cultural values within Pacific Island families. The culture of some families comprise only of traditional Pacific Island cultural orientation, others lean towards European values while others live their lives on a continuum stretching from traditional to European.<sup>134</sup> The foundation represents the family which is the foundation for all Pacific Island cultures.<sup>135</sup> This can include immediate and extended families. The four posts between the roof and the foundation connect the culture and the family but are also interactive with each other. These four posts represent the spiritual, physical, mental and other dimensions of a Pacific Islanders life.<sup>136</sup> Other refers to factors that can directly or indirectly affect health, such as gender, age, social class, employment, education and sexual orientation.<sup>137</sup>

This model incorporates values and beliefs of not just one Pacific Island nations but of Samoans, Cook Islanders, Tongans, Niueans, Tokelauans and Fijians and more specifically, it recognises the significance of family, culture and spirituality in the lives of many Pacific Islanders.<sup>138</sup> This model is therefore inclusive and insightful and should be adhered to if Pacific Island mentally disordered patients are to completely recover. It is important to remember that

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<sup>132</sup> Mental Health Commission *Pacific Mental Health Services and Workforce: Moving on the Blueprint*, above n 9.

<sup>133</sup> Tamasailau Suaalii-Sauni and others, above n 1, at 27.

<sup>134</sup> Ministry of Health *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review*, above n 20, at 30.

<sup>135</sup> At 30.

<sup>136</sup> At 31.

<sup>137</sup> At 2.

<sup>138</sup> Fuimaono Karl Pulotu-Endemann *Fonofale Model of Health* (September 2001) at 2.

“the model that needs to work for [Pacific peoples] has to make sure that it is robust enough to stand up clinically [and] that it is robust enough to stand up culturally”.<sup>139</sup>

## *VII Conclusion*

This paper has considered only some of the issues within the MH(CAT)A that when reformed, will cater to the Pacific population with mental disorder in a culturally responsive form. These are issues with the allocation of resources in community treatment care, issues with the definition of mental disorder, issues when deciding whether to consult or not and issues pertaining to respect for cultural identity. What is concerning is that the Māori, Asian and Pacific populations will all become a higher proportion of the total New Zealand population by 2038 because they will grow at higher rates than other groups in the population.<sup>140</sup> To ensure the MH(CAT)A is culturally responsive during this time of growth, patients must be vigilant in their resolve to guard themselves against the excessive powers of psychiatry” and other forces.<sup>141</sup> Although it has been argued that legislation for mental disorder should be abolished because it is an institutionalised form of discrimination,<sup>142</sup> conforming to this will provide more problems for Pacific Island patients because the numbers are growing and treatment is more critical than ever.

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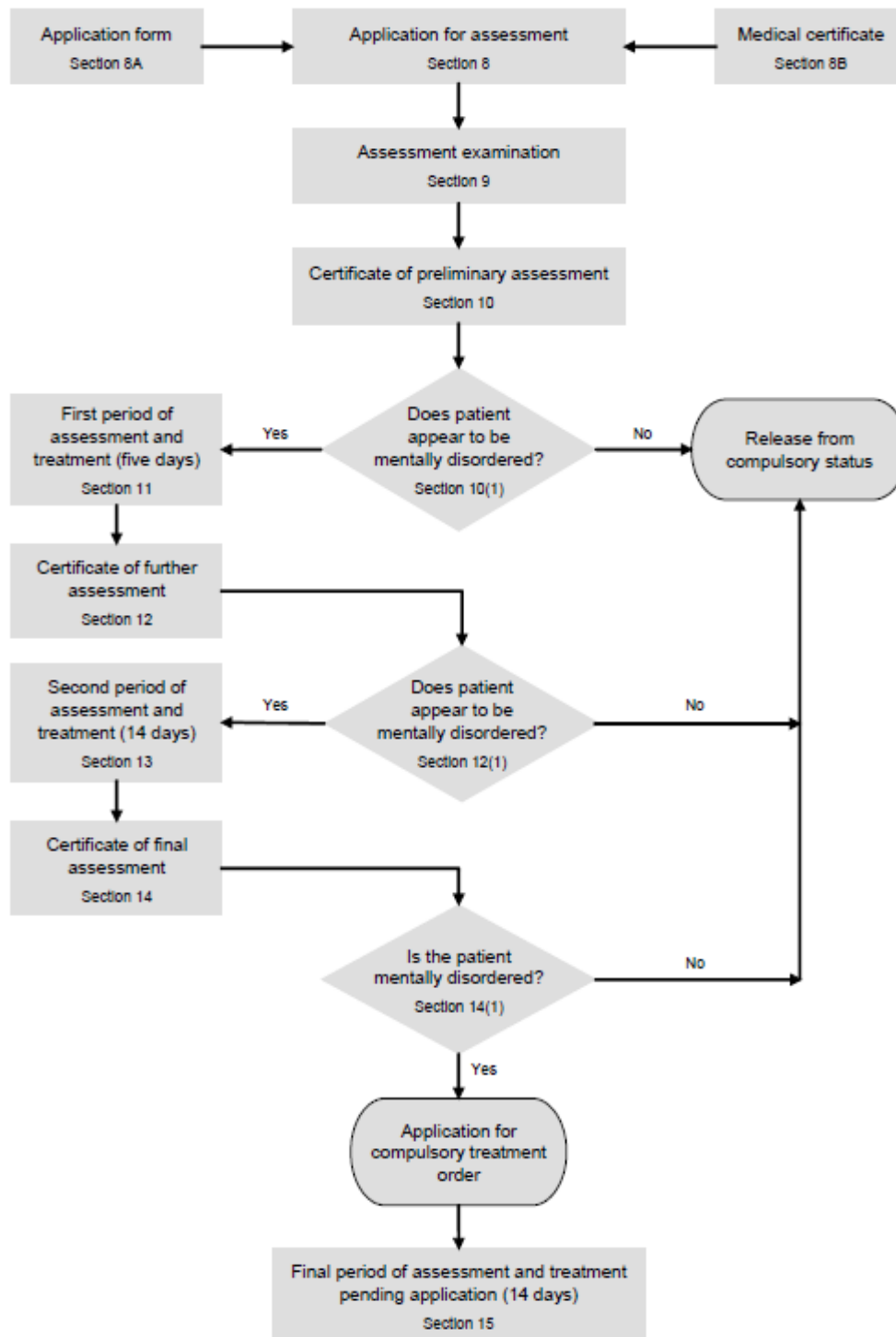
<sup>139</sup> Tamasailau Suaalii-Sauni and others, above n 1, at 27.

<sup>140</sup> Ministry of Health *Mental Health and Addiction Workforce Action Plan 2017–2021*, above n 8, at 4.

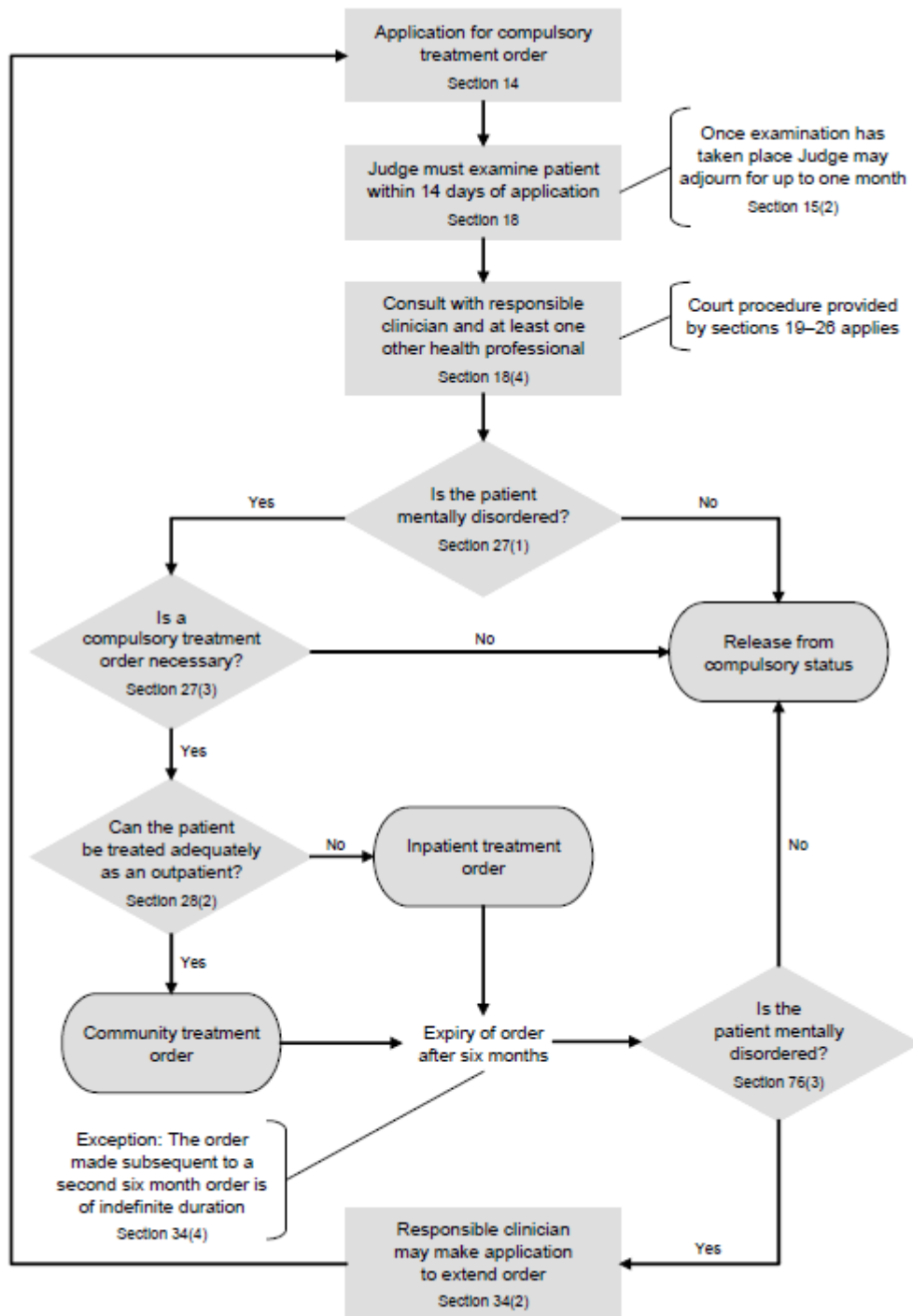
<sup>141</sup> Jonas Robitscher, above n 27.

<sup>142</sup> Tom Campbell and Christopher Heginbotham *Mental Illness: Prejudice, Discrimination, and the Law* (Dartmouth Publishing Co, Aldershot, 1991) at 94.

VIII Appendix 1



IX Appendix 2



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