The Law Association
OF NEW ZEALAND

Vero Center
Level 18
48 Shortland Street
Auckland City 1010
New Zealand
PO Box 58
1010 Auckland
DX CP24001
09 303 5270
thelawassociation.nz

Mental Health Bill

Submissions on behalf of The Law Association of New Zealand by the Mental Health and Disability Law Committee

INTRODUCTION

The Law Association of New Zealand (TLANZ) is an independent membership organisation for the New Zealand legal profession with approximately 7,000 members. TLANZ maintains expert committees that support legal review and policy advocacy on important issues. TLANZ Mental Health and Disability Law Committee ("the Committee") appreciates the opportunity to submit on the Mental Health Bill ("the Bill") on behalf of TLANZ.

The Committee is constituted of mental health advocates from across New Zealand. The Committee promotes disability awareness and rights; pursues reform; and develops projects on behalf of the legal profession.

SUBMISSIONS

1. The Committee supports the Bill's emphasis on reform of the Mental Health (Assessment and Treatment) Act 1992 ("**the Act**") to create legislation that:

    - reflects a human rights-based approach
    - promotes supported decision-making
    - aligns with the recovery and wellbeing model of mental health
    - is guided by Te Tiriti o Waitangi
    - provides measures to minimise compulsory or coercive treatment.

2. The Bill repeals and replaces the Act. It incorporates many of the above five factors in concrete and impactful ways which the Committee encourages. The Bill purports to provide more effective mental health care, supporting *compulsory* care to be delivered in a manner that, while minimising coercion, is responsive to individuals' needs. It adopts a recovery approach, offers greater protections than the Act and clarifies individuals' entitlements.

3. The Committee broadly supports the capacity-based orientation of the Bill. This corresponds with capacity-based legislation such as the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and the End of Life Choice Act 2019.

4. However, there is some concern from the Committee regarding the timing of the new legislation. If the new provisions are not funded properly, especially those relating to detailed capacity assessments, it will raise service users' expectations of a better systemic response to an individual's mental health issues. This is unfair and unkind if the resources are not in place. This was a major flaw in the Act where community care was lauded as a humane advance on institutionalisation but was not fully delivered due to inadequate resources.

5. The Committee is concerned that the capacity test is not reduced to a "tick box" exercise on a short standard form, as the first and second limbs under the Act have been.

6. The Committee queries whether the detailed analysis of capacity, similar to the capacity provisions under the current Protection of Personal and Property Rights Act 1988 (PPPRA), will be adequately resourced if the Bill is enacted. Capacity assessments obtained by the court under the PPPRA are expensive, time consuming and are often funded out of the estate. The Committee queries whether responsible clinicians will be resourced and have adequate time to make these assessments, given the Bill's goal of providing swift and humane interventions. The Committee is mindful that legal challenges in this regard would have legal aid implications and be costly to Whatu Ora.

7. The Committee observes that adequate training on capacity assessment will be vital for the wide range of professionals that are now qualified to be appointed as responsible clinicians.

8. The Committee supports Clause 5 that gives effect to the principles of Te Tiriti o Waitangi. This clause states the Bill's purposes include provision for compulsory assessment and care in a manner that improves equity in outcomes by striving to eliminate mental health disparities, particularly for Māori. It is beneficial that the Bill includes an explicit care principle that supports whanaungatanga and recognises the importance of family and cultural ties; provides for hui whaiora (well-being meetings); and rōpū whaiora (collaborative care teams).

9. The Committee acknowledges that the Bill demonstrates an effort to give effect to New Zealand's obligations under the United Nations Convention for the Rights of Persons with Disabilities ("**UNCRPD**").

10. The Committee supports the Bill's three compulsory care principles in Clause 6. However, to magnify the Bill's human rights foundations, the Committee recommends that "should" be replaced with "must" in all three principles.

    a. <u>Therapeutic purpose:</u> This beneficially focuses on recovery (to protect, promote and improve a person's health). It also provides that compulsion should only be used if "suitable care is available". This has a rights-protecting focus; if either criteria is not met, the person should not be subject to compulsion.

        i. However, the Committee recommends that the term "should be used" be replaced with "must only be used".

    ii. Also, the Committee inquires what provision will be made under the Bill if "suitable care" is not available but is needed to protect, promote and improve the person's health. More is needed in the Bill to demonstrate the Bill's recovery focus.

    iii. The Committee recommends that the Bill detail what efforts must be made to promote the person's recovery, in the event compulsory care is not available. The Committee is of the view that once the mental health service becomes aware of the person's ill-health, it has a duty to pursue support services for the person. In short, if a person otherwise qualifies for compulsory care, the person should not be abandoned because such services are not "available". The idea of "non-abandonment" might best be looked at in light of the United Kingdom's Care Act 2014. Under section 2, there is a duty to prevent the need for care and support being triggered, irrespective of eligibility for support services. Similarly, at section 4 there is a duty to "signpost" service users to other relevant services by providing information and advice if they do not qualify for support under the Care Act 2014.

b. <u>Least restrictive application</u>: The Committee recommends that for every person, staff members be required to document the specific least restrictive alternatives that have been explored or trialled, and how they determined that compulsory care qualified as the least restrictive option. This practice promotes active exploration of alternatives; provides transparency; increases accountability; contributes to procedural justice; and informs later care planning. That is, the exploration of alternatives provides a blueprint for care planning that promotes liberty and freedom.

    i. This is a safeguard in California under the Lanterman Act, which provides for the rights of people with developmental disabilities and their families to receive services and support. It requires staff to document why an intervention was the least restrictive option and the efforts staff made to find a range of autonomy-promoting options for people with developmental disabilities.

    ii. Similarly, in the United Kingdom, under section 1(6) of the Mental Capacity Act 2005, there is a requirement when making a care and support decision on behalf of a person who lacks capacity, to consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms, or whether there is a need to decide or act at all.

   c. Supportive and responsive application of compulsory care: The Committee supports the Bill's integration of UNCRPD principles. This includes perpetual encouragement of the person to develop and exercise capacity and choice; recognition of cultural needs; recognition of the person's will and preferences; and supported decision making. Additionally, the Committee supports the Bill's recognition of the significance of the person's ties to family, whānau, hapū, iwi and family group.

11. The Committee supports the Part 1 compulsory care criteria. "Mental disorder" is replaced with "seriously impaired mental health". The capacity criteria corresponds with contemporary capacity assessment under other New Zealand legislation and the common law. There is an explicit presumption that a person has capacity to make decisions about mental health care unless one or more of four criteria are met under Clause 9.

    a. The Committee is concerned that this presumption is undermined by the Bill's qualification. The Bill provides that assessors "may disregard brief or intermittent indications of capacity" at Clause 9(2)(b). This provision dilutes the Bill's commitment to the UNCRPD's rights-promoting principles and goal of encouraging the person to exercise capacity.

    b. The Committee recommends that Clause 9(2) include an obligation by staff members to *promote restoration of capacity* when they detect brief or intermittent indications of capacity. These efforts by staff members must be documented. (In the absence of this proposed provision, a person's intermittent capacity could be ignored or disregarded by staff members).

12. The Committee supports the provisions regarding care directives in Part 2, Subpart 1 of the Bill and the corresponding obligations on others.

13. The Committee supports the provisions regarding participation in decision-making. It notes that patients must be encouraged and assisted, to the maximum degree appropriate to their capacity, to participate in decision making. These provisions informatively detail how the Bill gives effect to promoting decision making, which is a primary purpose of the Bill. This is similar to the "person-centred approach" taken in the United Kingdon through section 1(3) of the Mental Capacity Act 2005, where a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

14. The Committee supports the inclusion of hui whaiora (well-being meetings).

15. The Committee supports the efforts to establish support networks in Clauses 18 through 24. The Committee appreciates the benefits of diverse forms of support, established in law.

   a. However, the Committee recommends that the distinction between these following roles be detailed: nominated person; welfare guardian; attorney (under the PPPRA); principal caregiver; independent support person; advocate; and lawyer.

   b. The Committee recommends that the Bill clarify how the interaction between these roles will be mediated. Clarification of the powers and duties of these roles will prevent confusion, duplication of effort, and reduce conflict.

16. In addition to clarification of the above seven roles, it recommends clarification of the roles of District Inspector (DI) and official visitor.

17. However, the Committee recommends that the official visitor role be removed. Arguably, it is based on an old model of regulatory oversight and inconsistent with the community focus of the Bill. It also seems unlikely to add anything not currently undertaken by the DI role.

18. The Committee supports extension of the existing rights under the Act to voluntary patients in inpatient facilities.

19. The Committee supports the updated processes for making complaints to DIs. The reforms improve accessibility, timeliness and transparency of the complaints process. Reforms beneficially include provision for DIs to obtain guidance from advisors regarding tāngata whaiora Māori.

20. The Committee supports the duty of decision makers to have regard to the views of the person and members of the support network at every assessment point. This activity will be guided by the Bill's principles and emphasise supported decision making. This is similar to the requirement in the United Kingdom under the wellbeing provision of the Care Act 2014 (section 1(3)(a)) where decision makers must begin with the assumption that the individual is best placed to judge their own wellbeing and have regard to their wishes, feelings and beliefs.

21. The Committee also supports the right to seek review or appeal decisions at each assessment stage and when an order is made.

22. The Committee supports the care planning provisions. This includes mental health support from inpatient care to community care, from compulsory to voluntary care. The Committee supports the Bill's requirement for routine reviews of the person's care plan and legal status. The network of safeguards demonstrates commitment to responsive, needs-based care for people subject to compulsory care.

23. Regarding Clause 100(2)(a), the Committee is pleased to see that (over two years ago) the Committee's earlier submission on the amendment MHA Bill has been incorporated. This clause corrects and renders practical the opportunity for patients to waive their right to an extension hearing. The word "solicitor" in section 34D(2)(a) of the Act has now been replaced with "lawyer" which now covers both barristers and solicitors with a current practising certificate. As most lawyers on the roster are barristers, this will now enable the provision to be used. The Committee stresses the importance of a protocol for ensuring that instructions can be taken by lawyers sufficiently in advance of the due date for the application. This will require cooperation of responsible practitioners and other health practitioners involved in the patient's care if the new provision is to have its desired effect.

24. The Committee recommends more stringent safeguards against seclusion, restraint and other restrictive practices. See:

    a. Roper, C., O'Hagan, M., Kennedy, H, Roennfeldt, H. (2021) Ending restraint: An insider view. In B. McSherry and Y. Maker (eds). Restrictive Practices in Health Care and Disability Settings: Legal, Policy and Practical Responses. Routledge. 16-38.
    b. McSherry, B. and Maker, Y. (2021) Regulating restrictive practices: Challenges and possibilities. In B. McSherry and Y. Maker (eds). Restrictive Practices in Health Care and Disability Settings: Legal, Policy and Practical Responses. Routledge. 295-301

25. The Committee notes that the Bill requires that every person performing a function under the legislation must use their best efforts to eliminate seclusion. The Committee recommends that this be replaced with "take all reasonable steps" and guidance could be detailed in corresponding regulations.

    a. Also, the Committee recommends that the Bill require that the Director of Mental Health, the Directors of Mental Health and all facilities serving people under compulsory care annually benchmark and report on their strategies to eliminate seclusion.

26. The Committee supports the Bill's creation of an offence for the neglect or ill-treatment of patients, proposed patients, and voluntary patients. The Bill provides that a person who *intentionally* ill-treats or *intentionally* neglects a patient, proposed patient, or voluntary patient commits an offence and is liable on conviction to imprisonment for a term not exceeding 5 years. However, many employees could argue that they did not have the intent to neglect and ill-treat a person in their care.

    a. The Committee has concerns that ill-treatment does occur under the present legislation due to care failures from inadequate resourcing. For example, it is not intended that suicidal patients be handcuffed or further traumatised by visits from police insufficiently skilled in mental health crisis situations, but it does happen.

b. Therefore, the Committee responds that the offence should not be based on intentionality. It proposes that a lower threshold be applied based on the person's *duty*, rather than intent. See the Crimes Act 1961, section 195A. Failure to protect child or vulnerable adult. It refers to an unlawful act or omission by a person who breaches their duty based on a *major departure* from the standard of care expected of a reasonable person with that duty. Note that the Crimes Act 1961 provides that the person may be imprisoned for up to 10 years (in contrast with the Bill's limit of 5 years).

27. The Committee supports the creation of a Forensic Patient Review Tribunal.

28. The Committee supports the inclusion of the guiding principles for the Mental Health Review Tribunal at Clause 171.

29. The Committee recommends that the Clause 171 principles apply to the Forensic Patient Review Tribunal.

30. The Committee supports the membership composition of the Mental Health Review Tribunal and the Forensic Patient Review Tribunal. Both will be required to have a member who has lived experience of compulsory mental health care.

CONCLUSION

In summary, the Committee generally supports the Bill's emphasis on creating a modern framework for compulsory mental health care while giving effect to Te Tiriti o Waitangi, recovery approaches and the UNCRPD. However, as above, the Committee has identified areas of the Bill that could be improved.

Thank you for the opportunity to make submissions in respect of the Bill. We are available to speak to any aspect of our submission if required. Should clarification be needed, please contact TLANZ Legal Services Manager, Dan Conway at:
daniel.conway@thelawassociation.nz

ACKNOWLEDGMENTS

The Committee and TLANZ acknowledges the contributions to the submissions by the following Committee members:

Professor Kate Diesfeld (Committee Convenor)
Professor Warren Brookbanks
Caroline Reynolds
Patricia Scriven
Dan Conway

Ngā mihi

Kate Diesfeld

Kate Diesfeld
Convenor
TLANZ Mental Health and Disability Law Committee