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Mental Health (Compulsory Assessment and Treatment) Amendment Bill

Submissions by Auckland District Law Society
Mental Health and Disability Law Committee

19 May 2021

Introduction

1. Thank you for the opportunity to make submissions on the Bill.

2. We strongly support a nationwide informed debate on mental health aimed at addressing the very real distress caused by mental illness. However, we see the solution as being led by very wide societal change, not a narrow legislative 'fix'. We question the need for urgency to amend the Mental Health Act before the Law Commission has conducted its review of the law. The review includes the Protection of Personal and Property Rights Act 1988 and broader issues of adult decision-making capacity. It is currently setting its terms of reference. Legislative reform of the current Mental Health Act s should encompass New Zealand's wider scope of human rights obligations.

3. The 'capacity' and human rights issues are complex in the mental health area and deserve full consideration. Constructively addressing specific mental health needs of Maori and Pasifika as recommended by *He Ara Oranga*, the recent Report of the Government Inquiry into Mental Health and Addiction, requires a full consultation with as wide a range of interested parties as possible, including those with an interest in patients' perspectives. Piecemeal amendments such as those contained in the Mental Health (Compulsory Assessment and Treatment) Amendment Bill are at risk of causing unintended adverse consequences to patients' rights, and damaging aspects of the current system that are working. We do not

support the use of the Covid 19 emergency response to permanently change the status quo. The rationale for change must be a significant improvement to the benefit of patients, rather than improving the 'administrative efficiency'[1] of the Act.

4. The Explanatory Note of the Bill asserts:
   "The amendments in this Bill are intended to improve the protection of individual rights and the safety of patients and the public and enable more effective application of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act)."
   - The Bill proposes to do this by eliminating indefinite treatment orders:
   - minimising the risk of harm to the patient or the public when transporting forensic patients who are special patients as defined under the Act:
   - addressing technical drafting issues that will improve the administrative efficiency of the Act:
   - removing the sunset date for technical amendments and audio-visual link amendments made by the COVID-19 Response (Further Management Measures) Legislation Act 2020.

5. We will now specifically address each of these areas of proposed amendment.

Eliminating Indefinite Treatment Orders

6. In respect of this proposal, the Explanatory Notes of the Bill state indefinite treatment orders have been widely criticised as a serious breach of human rights and their elimination is a significant policy reform that stakeholders and *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (November 2018) have clearly called for. The principal force behind that proposal seems to be New Zealand's international obligations, including under the United Nations Convention on the Rights of Persons with Disabilities.

7. We understand the importance of human rights principles but are concerned that this isolated amendment regarding indefinite treatment orders, lacking in appropriate context, will have a practical impact on a mental health service that is currently struggling, because of chronic underfunding and shortage of services and adequately trained staff. This is exacerbated by a critically significant New Zealand wide increase in mental health issues. That is made even more urgent by the clear indications that any post-Covid recovery must also address a new wave of

[1] Mental Health (Compulsory Assessment and Treatment) Amendment Bill 14-1 (2021) Explanatory note General policy statement.

mental health challenges.

8. Clause 8 of the Bill inserts amendments Section 34 to substitute a 12-month period for the current indefinite extension.

9. The amendment envisions that after the expiration of the first six-month extension of a compulsory treatment order, the order is to be reviewed under Section 76 with the emphasis for the order to continue for a further 12 months. This time frame is also extended by operation of the court process to potentially 14 months.

10. This is a long time for patients to wait be reviewed if they become well again after appropriate treatment in a few months. We accept that the process when review takes place now often results in a continuation of compulsion, but this is not always the case.

11. The amendment will require more scrutiny from the District Inspectors to check on reviewed clients who may wish to be released. The recourse for them would be an application to the Mental Health Review Tribunal.

12. We wish to see input from District Inspectors as to the mechanism for them to review clients in the community who may wish to challenge their status and wish to be released.

13. In our experience, it is common for the patient to prefer to step off the treadmill of repeated six-monthly hearings and consent to an indefinite extension. An alternative proposal would be to keep the provision for indefinite orders but insert an amendment that, after that stage, a patient is formally 'offered' the option of applying for a judicial (as opposed to Tribunal) hearing, say every 12 months. The District Inspectors could be tasked with that formality and sign off on it.

14. The proposed new Section 34(4) allows for an unspecified period for the order to remain in force without lapsing, until the court determines the application. This may be administratively convenient for 'the stakeholders' but its effect allows the court to delay, up to two months, in getting matters set down for hearing, without consequence.

15. So far as the amendment to Section 34C is concerned, this applies to the extension of community treatment orders by video link. We presume it is intended that the extension of

inpatient orders will be by way of the normal court process. Although currently there are not many inpatient orders requiring to be extended, there are some patients who remain under the Act who are still in hospital. An example of this is Buchanan Rehabilitation Clinic which is a scheduled hospital. Patients there can be voluntary or subject to inpatient or community treatment orders, depending on their situation.

Transport of Special Patients

16. The amendment relates to minimising harm to patients or the public when transporting forensic patients who are Special Patients as defined under the Act.

17. Clause 4 of the Bill inserts a new Section 53A Transport of Special Patients. This seems to give more oversight by the Director of Area Mental Health Services. There is no detail of the specific protocols proposed. We wish to see details of the Director General of Health's guidelines under Section 53(5). We are equally concerned about the transport of patients who do not fit into the category of 'special patient'

Addressing technical drafting issues that will improve the administrative efficiency of the Act

18. This is a very general statement that minimises the impact of proposals that it will amend. It covers the power for a judge to dispense with a hearing on written advice from a solicitor. "Solicitor" has the meaning given to it by Section 6 of the Lawyers and Conveyancers Act 2006.[2] We submit that the appropriate definition should be that of "lawyer". Our reason is that most of the lawyers currently approved to carry out mental health legal aid work hold practising certificates as barristers and are not required by legal aid regulations to have an instructing solicitor to carry out this field of legal aid work. The overwhelming majority of patients are represented by rostered legal aid lawyers. All are admitted and enrolled as barristers and solicitors but may hold differing practising certificates.

19. Our second concern is about the process for obtaining the client's written instructions, given the current processes and short notice surrounding the scheduling of hearings. A great deal of thought needs to be given as to how the rostered lawyers would obtain these written instructions and the specific nature of the documentation to be provided to the court. The

[2] Lawyers and Conveyancers Act 2006 Section 6

details should be worked out before this is enacted. There might need to be a prescribed form, and process for filing it. We note that occasionally a patient refuses to agree to sign anything in writing, whether because of illness or otherwise. Any requirements to have a patient's submissions or instructions put in writing need to be carefully considered before changes are made.

COVID 19 Response (Further Management Measures) Legislation-Removing the Sunset Clause

20. We oppose these amendments. They are more than technical. We appreciate the need for emergency provisions but submit that they can continue to be dealt with by way of renewal of Gazetted Epidemic Preparedness Notices.

Changes to Audio-visual Link Processes

21. Our experience of working with these changes toward increased use of AVL during the Covid emergency was that AVL hearings were not an adequate substitute for hearings in person. To widen their scope and make these provisions, without close examination of the consequences in practice, would negatively impact patients' rights to be heard.

22. Unlike bail or 'process' hearings in other jurisdictions, in Mental Health Act hearings, the Court is making substantive, 'final' decisions. What is more, the judge is required to examine the patient directly. This is because the patient's manner, behaviour and presentation is an evidential assessment the judge personally must make. Doing so through AVL is removing a significant dimension of any humane assessment.

23. We have found the technical quality of AVL supplied in different mental health facilities to have fluctuated greatly in quality. Quite apart from substantive issues, the use of AVL even for consultative purposes under the Act requires AVL that is secure and of sufficiently high quality to be available 24/7, with appropriate technical support.

Making permanent the emergency assessments by mental health nurses

24. We oppose this becoming ordinary practice as it represents a reduction in the required standard of training for assessors under Section 10. This power allows for an assessment that will require

the patient to submit to a five-day period of compulsory assessment and treatment, whether detained in hospital or monitored, and treated in the community. A serious commitment to human rights would require a person in this role to have a higher qualification, rather than an nursing qualification.

Additional Points for Consideration in Further Legislative Review

Section 16 Reviews

25. A member of our committee who has several decades of experience in the roles of District Inspector and subsequently Judge in mental health matters has raised a concern about the narrow jurisdiction afforded to Judges by the current Section 16 of the Act.[3] This provides for a patient under compulsory assessment and treatment in the initial phases of the exercise of powers under the Act to apply for an examination before a Judge who has the power to override a clinician's decision to continue with compulsory assessment and treatment[4]. The grounds for this are that the Judge must be satisfied that the patient is fit to be released from compulsory status. 'Fit for release from compulsory status' is defined as 'no longer mentally disordered and fit for release from the requirement of assessment or treatment under this Act.'[5]

26. Currently the Act does not distinguish between community patients and those detained in hospital. In both cases the Judge only has the power to release from compulsory status. We consider that these review powers should be extended to enable the Judge to override in appropriate cases a clinical decision to detain a patient in hospital but leaving intact a community process of compulsory assessment and treatment.

27. This issue has been problematic since 2000, when the Act was amended to include in Section 29, the provision to recall to hospital outpatients subject to compulsory community treatment order for either inpatient treatment for a period of up to 14 days, or a process of reassessment to see if an application for a compulsory inpatient treatment order is required.[6]

[3] MHA 1992 reprinted as at 7 August 2020
[4] S16(5) MHA
[5] Section 2 Interpretation
[66] See Section 29(3)(a) and 29(3)(b) MHA

28. The 2000 amendment gave the patient the right to apply under Section 16 if readmitted to hospital under either Section 29(3)a) or Section 29(3)(b), but limited the power of the Judge hearing the matter to a simple choice between 'compulsory' or 'voluntary'. This has been a source of difficulty ever since, as patients in this situation are often most aggrieved about the sudden readmission and detention in hospital, rather than their compulsory treatment in the community.

Lapse of Application for Compulsory treatment Order if not heard within prescribed period.

29. Currently a patient can avoid a compulsory treatment order by avoiding a scheduled court hearing until the statutory timetable runs out. The application lapses by operation of law, but there is provision for a fresh application to be brought.[7] We would recommend that this issue is carefully considered in a holistic review of the legislation, as it involves a balancing of fundamental patients' rights and the need for clinical intervention.

30. The Auckland District Law Society (Mental Health and Disability Subcommittee) members welcome the opportunity to consult in the future on revision and reform of mental health law.

[7] See Section 15(3) MHA