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Dear Select Committee

Thank you for the opportunity to submit to Parliament in relation to the draft Mental Health Bill. I am pleased to submit the following reflections on the proposed Bill which draw on our current research with the FACTORS Project in Australia and our broader expertise in mental health system reform.

Lisa Brophy

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Who we are

The FACTORS Project is a 3-year inquiry into the variations in the use Community Treatment Orders in New Zealand and Australia funded by the Australian Research Council.

The FACTORS team is an interdisciplinary group of experts from both countries including individuals with expertise in social work, law, psychiatry, lived experience and the social sciences. Collectively we hold a deep understanding of mental health legislation and the impact of human rights-based law reform including how well legislative innovations have fared in the Australian and New Zealand context.

FACTORS New Zealand lead is A/Prof Giles Newton-Howes. FACTORS team profiles can be found on our website:

https://www.latrobe.edu.au/research/ceri/research/care-experience/factors

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INTRODUCTION

The United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006) has generated numerous inquiries and subsequent reform of mental health legislation across New Zealand & Australia. These reforms have sought to bring mental health legislation in closer alignment with the CRPD and other international human rights treaties, including the United Nations Declaration the Rights of Indigenous Peoples. (UNDRIP). There is a consensus in the international community, however, that modern mental health legislation continues to fall short of compliance with the CRPD. Best practice in human rights based mental health law is set out in recent guidance from the World Health Organisation (WHO, 2023). The Guidance highlights the need to 'mainstream' provisions relating to mental health treatment and care rather than provide separate and exceptional laws. WHO also urges recognition of the right to access voluntary mental health treatment, the right to receive support for decision-making, the right to make binding advance directives and the right to appoint one's own psychiatric treatment decision-maker. While debates about the appropriate formulation of mental health laws remains unresolved, there has been a marked evolution in the content of mental health laws. The recognition of decision-making supports, advance directives and independent advocacy are positive developments.

The following analysis of the New Zealand Mental Health Bill recognises the positive features of the Bill, while providing a close analysis of the provisions concerned with compulsory mental health treatment in the community. These comments are informed by our ongoing research. While the Bill includes some positive features, it emphasises involuntary care in the community. Given the limited evidence of effectiveness of community treatment orders (Kisely et al 2021), referred to in the Bill as compulsory care in the community (CCC), and their disproportionate use amongst minority (Kisley & Xiao 2018) and Maori populations (Schneller at al 2018), there is a missed opportunity to embed alternative approaches to compulsory care which may to achieve better outcomes without compromising human rights.

Part 1 of the following discussion comments on the key feature of the legislation. Part 2 examines the provision relating to compulsory care in the community followed by discussion of the provisions.

Part 1: KEY FEATURES

The FACTORS team applauds the inclusion of features that should limit the use of compulsory care, especially those features that enable patients to assert their own choice with respect to care and treatment:

- **Clause 6 Compulsory Care Principles**: FACTORS notes with approval 6(1)(c)' Supportive and responsive application'[1] We suggest this principle be elevated and strengthened.

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[1] compulsory care should—(i)seek at all times to encourage the person to develop and exercise capacity and choice; and(ii)reflect the needs of the person, including their cultural needs, and be responsive to any trauma experienced by them; and(iii) be delivered in a manner that is responsive to, and guided by, the person's will and preferences; and(iv)recognise the importance and significance of the person's ties to their family, whānau, hapū, iwi, and family group, and the contribution those ties make to well-being.

- **Clause 7 Compulsory Care Criteria:** FACTORS notes with approval the strict civil commitment criteria which is (a) capacity based and (b) refers to seriously impaired mental health, and serious adverse effects in the near future. Strict civil commitment criteria, properly applied, should result in more targeted instances of compulsory mental health care. We note that the legislation requires automatic discharge from compulsory care if the criteria are not met.

- **Clause 9: Presumption and Definition of Capacity**: FACTORS welcomes the presumption of capacity, noting also that the definition of capacity aligns with common law principles. In our experience clinicians and other decision makers need guidance with respect to application of mental capacity principles in the mental health context. (see Ryan et al 2015; Ryan et al 2016). A human rights consistent analysis of mental capacity can be found in the Victorian case of PBU & NJE v Mental Health Tribunal [2018] VSC 564; 56 VR 141. In that case Justice Bell made the point that a capacity test will be "plain-bread discriminatory" unless a very low bar is set (at [178]).
    - **Given the emphasis on capacity, the general omission of references to support for decion-making or any formal system of decision-making support which privileges the will and preference of the person (who can exercise capacity with support) is a significant limitation of this Bill.**

- **Clauses 12-15**: FACTORS welcomes the inclusion of binding compulsory care directives which must be given effect to the extent that is reasonable and practicable. We urge the development of guidance on implementation of these documents.

- **Clause 16**: FACTORS welcomes the emphasis on patient participation in decision-making. We urge the development of guidance on implementation of this process.

- **Clause 17**: FACTORS welcomes the inclusion of Hui Whaiora (well-being meetings) (see de Jong et al, 2014: Sugiura et al, 2020). We urge the development of guidance on implementation of this process.

- **Clause 18:** FACTORS welcomes the recognition of a Support Network (rather than limited to one individual). We urge the development of guidance on implementation of this process.

- **Clause 19-22:** FACTORS welcomes the inclusion of nominated persons.

- **Clause 23:** FACTORS welcomes the inclusion of independent support persons. In our experience the most effective way to ensure independent support is to establish a dedicated support service. In Victoria these are called Independent (non-legal) Mental Health Advocates (see Weller et al, 2019).

- **Clause 24**: FACTORS welcomes the inclusion of advocates and the obligation to ensure a reasonable number of advocates are available. It will be important to articulate the supported decision-making role of these actors.

- **Clause 25-38: Patient Rights:** FACTORS welcomes the enunciation of patient rights and notes that proposed patients will also receive information about rights. FACTORS recommends that responsibilities for the communication of rights be made explicit and clearly operationalised. It is our experience in Victoria, Australia, that **services typically ignore or do not prioritise such obligations. Similarly, obligations placed on clinicians to explain rights are typically overlooked**. (Weller et al, 2019)

- **Clause 39:** FACTORS welcomes provision for complaints and note the accountability role of the District Officer.

- **Clause 41-42:** FACTORS welcomes the obligation to provide a responsible clinician and collaborative team.

- **Clause 43:** FACTORS welcomes the emphasis on care planning, including consideration of **physical, social, socio-economic and cultural needs of the individual**, and planning for transition to care in the community.

We note there is no mention of peer worker roles.

Part 2: COMPULSORY CARE IN THE COMMUNITY

The Draft Bill provides for compulsory care in the community in the form of an embedded model where compulsory care in the community is positioned as the preferred option. The assessment process for compulsory care is set out in Subpart 2. After an initial assessment, there must be a second assessment before day 19. If the treatment criteria still apply, an application will be made to the court. The court may make a mental health care order which is either a community care order or an inpatient care order (clause 77-79).

Clauses 63 and 77 establish the preference for community based compulsory care (referred to as outpatient care).

> **63 Location of compulsory care**
> (1) If, at any time during the second assessment period, the responsible practitioner considers that a patient who is an inpatient can continue to be assessed and given care adequately as an outpatient, the practitioner may give a written notice—
> (a) directing the person in charge of the hospital to discharge the patient; and
> (b) directing the patient to attend at the patient's place of residence, or at some other place nominated in the notice, for second assessment during the remainder of the maximum period.

Clause 63(2) allows for compulsory return to the hospital or detention in the hospital. Clause 77(2) requires the court to make a community care order "unless the court considers that the circumstances of the case require the patient to be treated as an inpatient." The court must be satisfied that the person (a) will receive care that is appropriate to their needs; and
(b) can be adequately cared for in the community (s77(3)).

Clause 78 sets out the parameter of a compulsory community care order. The order requires (a) that the person be present at their resident or another place to receive care, and (b) authorises clinical staff to ender the person's residence or another place.

> **78 Community care orders**
> (1)A community care order must require the patient to attend at the patient's place of residence, or at some other place specified in the order, for care by employees of the service, and to receive that care.
> (2) An employee of the service specified in the order who is authorised to provide care to the patient may enter the patient's place of residence or other specified place when reasonably necessary to provide care to the patient.

The words "or some other specified place" suggests that the order can direct the person to live in a place other than their usual place of residence. The care plan must be reviewed after 1 month and the patient status reviewed every 3 months. The order must be remade by the court after 6 months.

DISCUSSION

FACTORS acknowledges the statutory scheme sets out mandatory points at which a person must be assessed against the compulsory criteria to determine if they should be or should continue to be, subject to the legislation. At these points, decision-makers must have regard to the views of the person, their family and whānau and must be guided by the compulsory care principles. There is standing right to seek review of or appeal against decisions.

The compulsory care principles (s6) require compulsory care to be provided only to protect, promote and improve the person's mental health, that voluntary options be actively offered and preferred, and that the least restrictive option is used. The principles state that compulsory care should also be used in such a way as to encourage the person to develop and exercise capacity and choice and is responsive to the person's will and preferences.

In Australia, the inclusion of principles in legislation appears to have done little to alter coercive practices in mental health systems. As is noted above, in the absence of a robust implementation plan, supported decision-making mechanisms, independent mental health advocacy and legal support, it is difficult to see how principles alone can achieve their desired effect.

With respect to compulsory care in the community, the Bill says very little about the actual transition from inpatient compulsory care to compulsory care in the community. Community care is preferred, but there are no specific requirements, other than care being available. Apart from the obligation to discharge a person who no longer meets the criteria, and for the treatment plan to be followed there are:

- No limits on overall duration, noting that the care plan must be reviewed every 3 months
- No specific requirements to qualify for a CCC
- No obligation to ensure that treatment and care are provided.
- No obligation to provide support for decision-making.
- No obligation to transition to voluntary treatment.
- No principle of reciprocity governing the content of care plans.
- No obligation to provide a range of mental health, social or medical services.
- No obligation to refer patients to other psycho-social support services.
- No clarity with respect to the power to order where someone lives, or for how long.

- No second opinion or other similar service.

There are also a range of provisions that seem to counter the compulsory care principles. For example:

- Detailed provisions outlining powers to order the person to return to hospital care.
- Detailed provisions with respect to court powers, but very few procedural protections for patients. For example, there are no provisions ensuring information, representation and support be provided to the patient during the legal process.
- The court has power to accept or dispense with evidentiary requirements as it sees fit.
- The court also has the power to dispense with a formal hearing, albeit only with consent of a patient who has received legal advice (clause 100).
- There is a general requirement that the patient be present at the court, but clause 92(2) provides that the court may exclude the patient from any stage of the hearing if it is satisfied that—
  (a) attendance would have a detrimental effect on the patient's health; or
  (b) the patient lacks the capacity to understand the nature and purpose of the proceedings; or
  (c) the patient is causing such a disturbance that it is not practicable to continue with the hearing in the presence of the patient.
- There is no obligation to provide support or decision-making support.
- There is no obligation to ensure that advocacy or other supports continue to be provided in the community.
- There is no obligation to provide information.
- There is no obligation to provide rights information and support in the community.
- There is no avenue of appeal specified in the legislation.

In summary, community care is the preferred mode of compulsory care in this Bill. Despite the compulsory care principles and provision of advocates, there are few avenues that aim to ensure patients receive appropriate care in the community, can challenge the quality of care they receive, or are given the opportunity to challenge a community care order and be released from compulsory care. There are few opportunities for patients to exercise rights or challenge the care regime. Given the limited evidence of effectiveness and other impacts of compulsory community care, it is disappointing that the Bill does not appear to provide for alternative approaches, such as assertive outreach, which might achieve better outcomes without compromising human rights. If this Bill were to pass in this form, it seems unlikely that it will have a significant impact on current practice or reduce reliance on routine compulsory care.

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