NZ College of Clinical Psychologists
Te Whare Wānanga o te Mātauranga Hinengaro

Transforming our Mental Health Law

Consultation Regarding the Repeal and Reform of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The NZ College of Clinical Psychologists is a professional association that represents the interests of more than 1600 Clinical Psychologists registered in New Zealand. Clinical Psychologists are experts in mental wellbeing and disability, working across a large range of specialties and employers- including District Health Boards, ACC, Oranga Tamariki, Corrections, NGOs, PHOs and as private practitioners.

This submission was prepared by members of the College's Executive Committee and is based on the feedback submitted by our members.

1 Background

In preparing this submission, we (the College) recognise the significant shortcomings of the existing Mental Health (Compulsory Assessment and Treatment) Act, which is 30 years old this year. As the consultation document acknowledges, the current Act has been widely criticised for being in contravention of New Zealand's commitment to Te Tiriti o Waitangi, as well as domestic and international human rights law. This has led to regular and distressing breaches of individuals' human rights in the Mental Health system, as well as significant and growing inequities of outcome- notably amongst Māori.

There is significant overlap between the principles of Te Tiriti o Waitangi, as articulated by the Waitangi Tribunal, and principles of domestic and international Human Rights law. In particular, the principles of Tino Rangatiratanga, Equity and Active Protection have significant parallels in the so-called 'FREDA' Human Rights principles (Fairness, Respect, Equality, Dignity and Autonomy).

For this reason, rather than considering Te Tiriti and Human Rights Law as *secondary* to Mental Health law reform, our members have strongly argued that protecting and promoting an individual's rights- both under Te Tiriti o Waitangi and Human Rights law- should be the *primary* emphasis of a new Mental Health Act, which should be *directly* and *explicitly* be based upon these principles.

2 The Function of Mental Health Legislation *is* to Protect and Promote an Individual's Rights

The consultation document asks, explicitly, *"What should be the main purpose of mental health legislation?"* The experience of acute mental distress can, amongst a small number of individuals and under certain circumstances, present significant challenges to an individual's ability to stay alive (due to self-injury or vulnerability from others), to exercise their normal abilities to make considered decisions, or to maintain their dignity, relationships and standing in the community (mana).

The College would strongly argue that the ultimate purpose of new Mental Health legislation is to provide a framework for preserving an individual's rights under both Human Rights law and Te Tiriti o Waitangi (including their right to life, to exercise their rights to self-determination, and to maintain their relationships and their dignity), in the context of an episode of acute mental distress, as well as protecting the rights of others in their community. Such an approach would be far more in keeping with international and human rights law, as well as commitments under Te Tiriti o Waitangi,

compared to the current legislation whose primary aim is to enable the state to forcibly treat an individual against their will.

3 The legislation must allow others the ability to make (mental health) treatment decisions on behalf of an individual who lacks the capacity to do so themselves (as a result of a mental health condition).

Mental Health legislation must only ever be used to treat a diagnosable mental health condition- it must not be utilised to enforce treatments for physical conditions (unless those conditions are a direct cause of mental ill health), nor to allow decisions to be made with regard to an individual's property or general welfare. While compulsory treatment must be considered a 'last resort' (see principles of assessment below), our members believe that this *is sometimes* necessary, in a small number of situations, and therefore these circumstances must be detailed in the Act.

3.1 Compulsory treatment requires a 'two-part' test of a person's capacity to make decisions (about mental health treatment).

For compulsory treatment to be justified, our members argue that the Act should include a 'two-part' test, similar to that outlined in the UK Mental Capacity Act:

3.1.1 Part 1: A Diagnostic 'Test': Establishing that the person comes under the auspices of the Act.

- *Does this individual meet internationally agreed criteria (e.g. DSM or ICD) for diagnosis of a current mental health condition? (the term 'condition' is preferred to 'disorder')*

3.1.2 Part 2: A 'functional test': Establishing whether the person's condition prevents them from making reasonable decisions regarding their mental health treatment (e.g. to accept inpatient treatment, to take their medications).

- *Do the symptoms of that condition mean that the person is currently unable to make a specific decision relating to their treatment of that condition?*

This would represent a 'capacity' assessment similar to the test described in both the Substance Abuse Compulsory Assessment and Treatment Act (2017) and the End of Life Choice Act (2019), that the person be able to:

a) understand information about the nature of their condition and recommended treatments that are relevant to the decision; and
b) retain that information long enough to reach an informed decision; and
c) use or weigh that information as part of the process of making the decision; and
d) communicate the decision in some way.

3.2 Important Principles for Assessment of Mental Capacity

Our members have indicated that the current provisions outlined in, for example, the Substance Abuse Compulsory Assessment and Treatment Act (2017) and its associated guidance are currently insufficient to protect the rights of consumers under Te Tiriti o Waitangi and Human Rights law. The introduction of any assessment of capacity or otherwise must be informed by the following principles, which we believe should be explicitly stated in the legislation:

i. *Presumption of capacity*. The person should be presumed capable, unless significant evidence exists to the contrary.

ii. *Supported decision making*. The person should not be treated as incapable of making a decision unless all practicable steps (including providing information in appropriate language and format) have been tried to help them understand the information (required to make a decision).
iii. *Ability to make 'unwise' decisions*. A person should not be treated as incapable of making a decision, because their decision may seem unwise to others.
iv. *Best interests*. Decisions made for people who lack capacity must be demonstrably in their 'best interests' (and must, therefore, consider negative aspects of forced treatment).
v. *Least restrictive alternative*. Before taking action or making a decision on behalf of that person, consideration must be given as to whether the outcome could be achieved in a less restrictive way. Compulsory treatment must only be undertaken for the minimum time possible to achieve the intended outcomes.

The principles are similar to those informing similar capacity legislation in the UK. In addition, our members have raised the following points:

- Since detention would be on the basis of a need for treatment (and an ability to consent or not to that treatment), assessors must clearly communicate to consumer with the details of the recommended treatment, as well as the advantages and disadvantages of accepting or declining treatment.
- Assessors must also consider whether that treatment or decision is required imminently (i.e. the person's life, or the lives of others are in imminent danger) or whether it can be delayed until such time as the person has developed sufficient capacity to be involved in their care.
- A lack of capacity must be due the mental condition described in 'Part 1' and not as a result of other cognitive, sensory nor intellectual disabilities.
- Capacity is decision-specific. The person may be unable to give informed consent regarding one aspect of their care (e.g. inpatient treatment) but may, at the same time, be able to give informed consent regarding other aspects (e.g. medication use).
- Further protections must be given to vulnerable individuals who lack capacity but are compliant with treatment (c.f. Bournewood case in the UK).
- Assessment of capacity requires a complex understanding of cognition, motivation, mental health and behaviour. Clinical Psychologists are experts in these fields, particularly in the area of cognition. Where it is unclear whether the person has the ability to weigh, retain and balance information relevant to their treatment, *there should be provision for further assessment by a suitably qualified psychologist*, in addition to assessment by a psychiatrist.

5 Safeguards to Ensure the Protection of a Person's Rights

In addition to the principles of assessment under the Act, detailed above, our members have argued strongly on the point of 'Best Interests' decision making, which may be considered related, in some aspects, to the principle of 'Active Protection' under Te Tiriti o Waitangi. In this context, the history of New Zealand itself suggests that the assumption that powerful individuals or organisations (e.g. The Crown, Health Services) can make unbiased decisions as to the 'best interests' of others (e.g. Māori, Mental Health consumers) is likely to be naïve, at best.

6.1 The need for statutory provision of independent advocacy

We submit that 'best interest' decisions should not be made by treating clinician, nor should they be made by family, nor by pākeha/tauiwi on behalf of Māori consumers. Capacity legislation overseas

includes the requirement that 'best interest' decisions are made by an independent advocate, rather than by the treating physician or by a proxy (e.g. family- although the advocate must take account of their wishes). Our members submit that independent advocacy is central to safeguarding the individual's rights under Te Tiriti o Waitangi and/or Human Rights law. In the case of Māori, Te Tiriti principles suggest that appropriate kaupapa Māori options for advocacy must be made available- with a duty that an appointed advocate consult with whānau, hapū and iwi reaching a decision.

6.2 Provision of suitable alternative treatment options

Most advocates, legislators and clinicians agree that compulsory treatment should be considered only as a matter of 'last resort', where all other suitable alternatives have been tried. While it may not be within the purview of this consultation, implicit in this requirement is that alternative options for compulsory treatment are made available to consumers. As was noted by the He Ara Oranga report, options for community treatments- including proactive, psychological and social approaches, options for psychological therapy and non-compulsory residential treatments- are currently poorly provided within mental health services in New Zealand.

For this reason, our members would reiterate that a legal requirement to utilise compulsory treatment as a 'last resort' and to utilise 'least restrictive practices' is likely to be extremely difficult to implement (and therefore somewhat meaningless) without further investment in alternatives to current treatment services.

6.3 The role of the Police in enforcing the Mental Health Act.

Our members have indicated that they feel that the police should have as little involvement in administration of the Mental Health Act as is reasonably possible, since this is a Health issue rather than a Criminal one. While we understand that the police may require powers to detain individuals for a (very) short time to take them to a place of safety for mental health assessment, no person experiencing mental distress should be detained in a police cell, as has often occurred in the past. We would recommend that any revision of the current Act should make it explicit that an individual detained by the police for assessment must be immediately transported to a suitable (mental health) assessment facility.

7 Summary

The New Zealand College of Clinical Psychologists agrees with the findings of He Ara Oranga that the current Mental Health (Compulsory Assessment & Treatment) Act requires repeal and significant reform.

As noted within the body of the consultation document, the current Act has been widely criticised for being in contravention of New Zealand's commitment to Te Tiriti o Waitangi, as well as domestic and international human rights law. This has led to regular and distressing breaches of individuals' human rights in the Mental Health system, as well as significant and growing inequities of outcome- notably amongst Māori.

In summary, the College of Clinical Psychologists submits that:

- The function of Mental Health legislation is, fundamentally, to protect and promote an individual's rights. An individual's rights should be explicit in the wording of the Act and/or subsequent guidance.

- The legislation must allow others the ability to make (mental health) treatment decisions on behalf of an individual who lacks the capacity to do so themselves (as a result of a mental health condition).
- The Ministry of Health should consider a 'two-part' test as to whether an individual requires compulsory treatment- including both a 'diagnostic test' and a 'functional test' of eligibility.
- The above tests must be based on international best practice, with regard to assessment of mental health conditions, and in assessment of capacity.
- A number of human-rights based concepts and principles (including the presumption of competence, supported decision making, least restrictive intervention and 'best interests') must underpin all aspects of this legislation and should be explicit in any subsequent guidance.
- 'best interest' decisions should not be made by assessing clinicians, nor is it appropriate for these decisions to be made by family members, nor by pākeha/tauiwi on behalf of Māori consumers.
- All individuals who are considered to be lacking capacity to make decisions should be provided an independent advocate, whose duty it would be to take into account the wishes of the person, their family (or whānau, hapū and iwi), and the treating clinicians.
- In order for compulsory treatment to be truly a method of 'last resort', significant investment is required in alternative treatment approaches- including psychological, social and (voluntary) residential treatments- for individuals experiencing significant mental distress.
- Assessment and treatment of Mental Health conditions is a matter for Health services and, as much as possible, should be taken out of the hands of the police. Where an individual is detained by police due to mental health concerns, they should be immediately transported to a suitable (mental health) assessment facility.

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