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

Submission to Te Aka Matua o te Ture | Law Commission

He Arotake i te Ture mō ngā Huarahi Whakatau a ngā Pakeke | Review of Adult Decision-Making Capacity Law

1 Clinical Psychologists and Capacity Law

The NZ College of Clinical Psychologists ('the College') welcomes the review of decision-making 'capacity' law in Aotearoa New Zealand, which our members consider to be extremely timely.

The College is a membership-based professional association, representing one of the largest and most specialised workforces in neurodisability/neurodiversity and mental health. Clinical Psychologists are registered practitioners under the Health Professions Competency Assurance Act 2003, and there are currently approximately 1850 clinical psychologists registered with the New Zealand Psychologists Board. Clinical Psychologists have extensive training in cognition, behaviour, neurodiversity and mental distress and are frequently involved in both formal assessments of 'capacity', particularly under the PPPR Act (1988), in medico-legal cases, and in more informal situations where there are concerns about an individual's ability to make informed decisions.

2 Background

As the Preliminary Issues Paper (PIP) suggests, our members note that the question of 'capacity' to make decisions is a *highly* complex one. More than a century of psychological research suggests that decision-making involves a complex interaction between the individual, the characteristics of the decision to be made, and the context in which that decision is made- including the influence of others on the decision maker. No two decisions are the same and no two people will think in exactly the same way. Decisions made in discussion with others, are often different to those taken alone. A person's thinking can change, depending on when you ask them and what information they are provided. Some decisions are potentially life-changing (and life-saving or life-ending), others may seem relatively inconsequential. As the PIP suggests, **a legal framework that does not reflect this diversity and complexity is will almost certainly fall short of its intention to protect vulnerable New Zealanders**.

3 Specific Feedback on the Preliminary Issues Paper

3.1 Terms Used in the Review

We would like to congratulate Te Aka Matua o te Ture/Law Commission ('the Commission') on its thoughtful approach towards use of language in this review, which is welcome. **Our members would fully support the majority of the proposed approaches to language, while noting that the move to more general language runs the risk of losing the precision of more specific language use**. For instance, in S4.5, the Commission has chosen to conflate the concepts of 'competence' and 'capacity' (including a number of variations). While competence and capacity are frequently used interchangeably, they do have distinct (technical and legal) meanings which are useful in discriminating different states. Competence is more typically used to speak of a set of skills that a person has or has not and is typically determined legally (e.g. competent to stand trial), whereas 'capacity' is a judgement of the person's ability to engage in a process, which may involve being taught 'competencies', and is typically a judgement made by a clinician. Our members have some concerns that nuanced understanding of this kind could potentially be lost and we would urge the Commission to consider this carefully, including whether an appropriate glossary of terms may be appropriate.

More specifically, a number of our members voiced significant concerns with the use of 'learning disability' as a catch-all for people with cognitive disabilities. We would certainly support the use of the term 'learning disability' to describe the difficulties of people who might otherwise be described as having an 'intellectual disability'- this is regularly advocated for by user groups as a preferred term and is widely used overseas, particularly in the UK. However, we would suggest that **this represents only one group of people whose cognition is impacted**- most people with dementia, acquired brain injuries, stroke, multiple sclerosis or other neurological conditions would not, normally, describe themselves as having a 'learning disability'. In attempting to use inclusive language, we would suggest that the Commission could, unintentionally, limit discussion of the unique needs a number of groups of people to whom this legislation is highly relevant.

3.2 'Functional' Tests of Capacity

In the PIP, the Commission makes the point that the law typically takes a 'functional' approach to assessment of capacity and discusses some of the advantages and disadvantages of such an approach. While our members agreed with this assertion, it was noted that, outside of a court, concerns about capacity (and restrictions of a person's rights) are more typically driven by factors related to 'outcome' and 'status' approaches. That is, a person's capacity to make decisions is rarely called into question by others unless the person either a) is perceived to make choices that are perceived as highly 'risky' or otherwise out of character for them and/or b) are perceived to be experiencing a physical,

developmental or mental health condition that has affected their ability to make decisions. These 'status' and 'outcome' assessments are frequently the initial 'trigger' which prompts lay people (and frequently trained professionals as well) to question a person's capacity.

Not all decisions are equal in terms of their implications and outcomes. New Zealand's End of Life Choice Act represents one example of legislators placing a higher burden of proof for 'capacity' (or 'competence' in the Act), due to the implications (or 'outcome') of a decision to end your own life. Furthermore, the current definition in the PPPR Act focusses on the ability of the individual to 'foresee the consequences' of their decision, implying some importance on what those consequences may be. Overseas legislation such as the UK Mental Capacity Act (2005) has included a 'two stage' assessment of capacity, which includes both a 'status' assessment (does the person have a condition that might affect their decision-making) and a 'functional' test, which we would advocate. Furthermore, the Mental Capacity Act Code of Practice makes it clear that capacity may be questioned when "the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision" (P52).

While a person's right to self-determination is clearly paramount, our members noted that New Zealanders have a number of other important rights that must be also protected- including the right to life and the right to be free from inhuman or degrading treatment. Our members also suggested that, in Te Ao Māori, as well as the cultures of local Pacific nations, risks to relationships and personhood- including concepts of mana, whakamā or Le Va- may be seen by some to be equally as important as risks to life, body or material possessions. The need to protect a person's rights and 'personhood' must be considered and balanced in designing future capacity legislation and guidance.

3.3 Te Ao Māori, Tikanga Māori and Principles of the Review

College members strongly support the approach taken by the Commission with regard to Te Ao Māori and Tikanga Māori, as well as its commitment to the principles of Te Tiriti o Waitangi. College members felt that the aspirational principles, according to which the Commission proposes to conduct its review, appeared to be appropriate and well-considered.

3.4 Decision-making Supporters

Our members reported experience of being and interacting with decision making supporters in a wide range of contexts. Many of our members have experience of formal decision makers, such as welfare guardians in New Zealand, and Independent Mental Capacity Advocates (IMCAs) in the United Kingdom. In this context, **our members stressed the importance of an 'independent' support person** in decision making and that this was frequently problematic if this decision-making power was given to a relative, friend or a clinician. Those members who had

previously worked in the UK reported positive experiences of the IMCA service, who are engaged under certain circumstances to support the person with high-risk or 'material' decisions, such as consenting to 'serious' medical procedures or placement in hospital or other accommodation over a certain threshold. More informally, our members note that carers (and professionals) frequently support people with 'everyday' decision making- such as what they should have for their meals, what they should wear, how they should travel to their appointments, etc. Our members wished to make it clear that, even if a person is believed to lack capacity to make decisions about a broad set of issues (e.g. 'finance') they are frequently still able to indicate their preferences in simple, 'every day' decisions. For this reason, new capacity law must be sufficiently flexible to allow people to make choices when they are able, but to provide supported, or substituted decisions when they are not.

3.5 Advanced Directives

Our members reported some involvement in the use of advanced directives, however they noted that they frequently were not enacted according to the person's wishes- partly due to the lack of clear legal standing of the documents. In some cases, this was seen as a positive- where new information became available when the decision was made (e.g. treatment options), that was not available to the person at the time of writing the advanced directive. We also received reports of care recipients who had prepared an advanced directive but changed their mind when they had to directly face the situation described in the directive.

3.6 Supporting Supported Decision Making

Many of our members who commented felt that there was significant scope for the development of guidance, templates and proformas to aid non-psychologists in considering capacity, 'best interests' and 'least restrictive practice'. Several of our members who had worked in the UK, within the provisions of the Mental Capacity Act (2005) spoke of the benefits of the clear guidance and assessment templates in guiding decision making.

3.7 Safeguarding

Our members strongly endorsed the need for balances and checks for people whose liberties are restricted due to questions of 'capacity'. The College has previously called for the explicit use of the principle of the 'least restrictive alternative' in our submission on the reform of the Mental Health Act, and we would reiterate that assertion here. We would suggest that restrictions would need to be shown to be 'necessary' and 'proportionate' on a regular basis- including being in place for the shortest time possible- to be compliant with human-rights based

approaches. Unfortunately, our members described encountering many situations in New Zealand where decision makers did not act in the interests of the person themselves, but our members felt they currently had few mechanisms to intervene. The Commission may already be aware of the 'Bournewood' case in the UK, which has led to stringent 'Deprivation of Liberty Safeguards' as part of the UK's Mental Capacity Act. The College would suggest that consideration should be given by the Commission to similar safeguards in New Zealand.

3.7 Other Issues Raised by Our Members

The College has previously made an extensive submission on the question of 'capacity' to the consultation on the repeal and reform of the Mental Health Act, which we feel is highly relevant to this review. In our submission, we argued 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 above provisions are similar in nature to those described in the UK's Mental capacity Act (2005). In the same submission on Mental Health Law Reform, we also noted that:

- *"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…"*

While we note that the Commission is at an early stage of its consultation, we consider the above principles to be extremely important in designing New Zealand's future capacity law. We look forward to further consultation with the Commission on this issue.

4 Summary and Conclusions

- The NZ College of Clinical Psychologists is fully supportive of the intent of the Commission's review of 'capacity' law, which our members consider to be significantly overdue.
- Our members note that the question of 'capacity' to make decisions is a *highly* complex one. In our opinion, a legal framework that does not reflect the diversity and complexity of these decisions will be likely to fall short of its intention to protect vulnerable New Zealanders.
- We applaud the Commission for its attempts to utilise inclusive language in its review, however our members have concerns that the use of general language could risk losing important concepts and definition.
- In particular, our members expressed significant concern at the use of the term 'learning disability' to describe *all* people with neurodiversity/neurodisability- the term 'learning disability' is typically only used to describe people with developmental (or 'intellectual') disabilities and would not be embraced by most people who have experienced other cognitive injuries, such as stroke, acquired brain injury or dementia.
- While the Commission rightly draws specific attention to 'functional' tests of 'capacity', we would urge the Commission to also consider whether 'status' and 'outcome' based considerations may be of importance. The risks associated with some decisions may be considerable, and we would question whether it is appropriate to question a person's mental capacity in the absence of any illness, disability or condition that would affect their ability to make decisions.

- Our members are supportive of the approach the Commission has taken so far in regard to considering Te Ao Māori, Tikanga Māori and Te Tiriti o Waitangi, as well as the principles underlying the review.
- Our members have described their significant preference for 1) increased availability of independent advocacy/decision supporters, outside of direct family, friends and clinicians, 2) guidance and assessment templates, such as those associated with the UK's Mental Capacity Act legislation, 3) clear safeguarding procedures that ensure that decision makers are utilising the 'least restrictive approach'.
- In keeping with our submissions to other consultations regarding NZ's mental health law, we have made a number of recommendations regarding the principles that we feel should underlie future legislation and guidance.
- As we have submitted elsewhere, Clinical Psychologists are experts in understanding decision making processes, as well as the impact of neurodiversity and mental distress. For this reason, we would suggest that Clinical Psychologists should be significantly involved in (more complex) decisions regarding an individual's 'capacity'.

Many thanks to the Commission for undertaking this review and for the opportunity to respond. We hope the above information is useful to the Commission in its preliminary consultation and we look forward to future opportunities to contribute to this discussion.

The New Zealand College of Clinical Psychologists, 3rd of March, 2023

The New Zealand College of Clinical Psychologists is a professional association that represents the interests of more than 1850 Clinical Psychologists registered in Aotearoa.
Clinical Psychologists are experts in mental wellbeing, behaviour and neurodiversity, working across a large range of specialties and employers-
including Te Whatu Ora, ACC, Oranga Tamariki, Ara Poutama, NGOs, PHOs and as private practices.

This submission was prepared by the College's Executive Committee,
with the direct support of our members and consultation with wider experts in the field.