Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

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Law Commission
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Submission on the Law Commission Review of Adult Decision-Making Capacity Law (Second Issues Paper)

Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora
He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, anei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora Hinengaro

Introduction

The Mental Health Foundation of New Zealand (MHF) welcomes the opportunity to submit on the Law Commission's Review of Adult Decision-Making Capacity Law in New Zealand.

Our submission on the Preliminary Issues Paper focused on decision-making within the mental health system – specifically, the experiences of those whose right to make decisions about their personal care and treatment, is, or has been, overridden under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). While this Second Issues Paper is centred on the Protection of Personal and Property Rights Act 1988 (the PPPR Act), and does not deal specifically with decision-making capacity as it relates to mental distress or mental health treatment, we consider that the legislation to replace the PPPR Act could carry significant weight for people experiencing mental distress in the following ways:

1. The proposed test for determining decision-making capacity, and the suggestions for embedding decision-making support, Te Tiriti o Waitangi,

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tikanga, and collective decision-making, may set a precedent for how these same issues are considered in the upcoming reform of the Mental Health Act.

2. The Act to replace the PPPR Act will impact people whose decision-making is affected by mental distress.

Our submission provides high level feedback focused on these two considerations, rather than a response to each individual consultation question.

Throughout our submission we use the term 'tāngata whaiora' (people seeking wellness) to refer to those with lived or living experience of the Mental Health Act.

Consideration of Te Tiriti o Waitangi, te ao Māori, and tikanga *(Q1-Q2)*

The MHF supports reforming the PPPR Act to give better effect to Te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). We agree with the acknowledgement that Māori enjoy greater wellbeing when enabled to exercise tino rangatiratanga or collective self-determination and "live as Māori" in accordance with tikanga. We also support tikanga being recognised in the new law in a flexible, non-prescriptive manner, to avoid dulling its depth and complexity and allow for local variation in its expression.

We approve of the assertion that reshaping decision-making arrangements to be more accessible and culturally relevant for Māori is likely to promote greater equity of outcomes. This shift in direction, including the ways in which a new Act may better enable Māori to live in accordance with tikanga and provide for the involvement of Māori collectives in decision-making, summarised at paragraph 4.16, is something we would like to see replicated in mental health law and practice as well.

We recommend the new law and processes are co-designed with Māori.

Human rights and the purposes of the new Act *(Q3)*

The MHF supports aligning the new law with the New Zealand Bill of Rights Act, international law, UNDRIP and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). We agree the purposes of the new Act should prioritise upholding human rights (including, as the UN Committee on the Rights of Persons with Disabilities argues,[1] the right to take risks and make mistakes), and that "protection from significant harm" should be justified only to the extent required to protect their dignity and human rights.

[1] In General Comment No 1 (United Nations, 2012).

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The threshold for harm should be high. We know that in the mental health system, law and practice have not struck the right balance between keeping people safe and maximising their recovery through self-determination. As discussed in *He Ara Oranga*,[2] risk aversion and defensive practice do not typically result in good outcomes for tāngata whaiora:

> Clinicians working under the Mental Health Act... have unsurprisingly developed a culture of risk aversion and defensive practice. This is a problem that extends beyond interpretation of the Mental Health Act, but many highly publicised cases involve decisions made under the Act. It is based on the flawed premise that risk prediction is an exact science. Instead of focusing on the patient's best interests, too often clinicians attempt to 'manage risk'. The results are not always good for patients, clinicians, [whānau] or, ultimately, the community.

Decision-making capacity *(Q4-Q9)*

The MHF agrees that the standards and processes for assessing decision-making capacity, and the consequences that flow from the assessment, should be amended to prevent unjustified discrimination, address practical issues, and better reflect the diversity of social and cultural contexts that are relevant to people's decision-making. Specifically, we support retaining the statutory presumption that a person has decision-making capacity, and assessments being carried out in appropriate physical environments and with supports that enhance people's decision-making.

We also support the option for assessments to be carried out by people other than medical practitioners. In the mental health system, our consultation with tāngata whaiora has told us that the privileging of psychiatric and medical expertise has resulted in tāngata whaiora being assessed on the basis of their clinical histories or notes from previous periods of unwellness rather than their current circumstances. In addition to increasing guidance and training for all professionals conducting decision-making capacity assessments, we think expanding the range of potential assessors (to include professionals like peer workers, for example, who operate with different underlying perspectives and experiences than clinical workers) would support a shift to a more person-centred, whanaungatanga-based approach to assessment.

We recommend the Law Commission consider previous/current diagnosis of a mental health condition, and/or being subject to a compulsory treatment order under the Mental Health Act as factors being insufficient, by themselves, to find that a person does not have decision-making capacity.

[2] Government Inquiry into Mental Health and Addiction, 2018.

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Decision-making support *(Q10-Q12)*

As stated in our submission on the Preliminary Issues Paper, the MHF has an established position that supported decision-making (or decision-making support) must be embedded in the legal framework of our mental health system, and substituted decision-making[3] should be abolished.

We understand the Law Commission is not, in this review, considering all possible initiatives and reforms required to ensure all people with affected decision-making have the support and reasonable accommodations they need to make decisions. However, we do anticipate that recognising decision-making support throughout a new PPPR Act could establish best practices, guidance and familiarity that might promote and aid its application in other contexts.

We also believe there are lessons from the mental health system that are relevant to the ways in which the law to replace the PPPR Act might incorporate decision-making support. These include the following recommended practices or conditions:

- Full and non-biased information about rights, legislation, and processes (including information about decision-making supports that are available) should be provided to the person with affected decision-making and their whānau, loved ones and/or other chosen supporters. The information should be presented in a clear and understandable manner and be available in different formats, and adequate time and support should be given to comprehend the information.
- The time and setting of the decision should be physically, spiritually and emotionally safe. Where possible, the person whose decision-making is affected should be enabled to choose the time and place, with the option of selecting their own home and/or a time outside normal working hours.
- The decision-making process should be inclusive of supporters such as peers, whānau, significant others and other supporters.
- Decision-making practices should enable tikanga Māori and be culturally relevant and safe for Māori, such as through valuing wairuatanga and facilitating collective decision-making.

[3] By which we mean an arrangement where someone makes a decision for another person in their 'best interests' without providing support to establish their will and preferences in respect of that decision.

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- Where a decision is not urgent, there should be no deadlines or time pressure to make the decision. People should be given adequate time to reflect and confer with people they trust.
- Genuine choice and options should be provided where possible (e.g., in respect of decisions about living arrangements or medical treatments).
- There should be regular opportunities to review and/or change decisions and reflect on or debrief the way they have been applied. Any deviations from communicated wishes should be fully justified, recorded and communicated to the person being supported to make a decision.
- Pre-event tools, such as advance directives or other proactive statements of wishes, should be available.

  (Gordon et al., 2022).

The MHF supports incorporating supported decision-making throughout the new law as the preferred arrangement, to encourage its use and prevent over-reliance on representative arrangements.

Advance directives and decision-making arrangements *(Q80-Q87)*

The MHF advocates for system and law changes to support increased use of advance directives in mental health settings in Aotearoa. We know their use can reduce involuntary hospital admissions and enhance recovery (Delman et al, 2015; Premski et al., 2010; Tinland et al., 2022; Tinland et al., 2019). Pre-planning arrangements (including but not limited to advance directives) have been identified as a meaningful supported decision-making tool for tāngata whaiora (Gordon et al., 2022).

We have heard through consultation that many tāngata whaiora and their whānau have either not been made aware of advance directives, or have not had their advance directives upheld by mental health services. While we understand this review is not considering when advance directives should be binding on health professionals, we think expanding the circumstances in which they should be considered in decision-making arrangements under the new PPPR Act will lead to greater awareness and potentially increase their use.

We agree a new Act should allow for valid advance directives to be followed by both representatives and attorneys. We recommend the new law give advance directives as much weight as possible, and provide that they should only be departed from in exceptional circumstances (such as when a directive is old and there is evidence the person's will and preferences have changed).

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Improving court processes *(Q96-Q101)*

The MHF recommends better enabling people with affected decision-making, their whānau, and other supporters to be involved and participate meaningfully in court processes. This includes assistance to understand the process, the meaning of terms used, and where and how to access support to attend and participate. It also includes ensuring court processes and settings are comfortable and non-punitive, and staff are culturally competent. We strongly support adapting models like Te Ao Mārama, including its suggestions to use plain language, revised courtroom layouts, and tikanga Māori, for court proceedings under the new PPPR Act.

Thank you for the opportunity to comment on the second stage of your review into adult decision-making capacity law in Aotearoa. We look forward to reading your final recommendations for reform in 2025, and seeing the new Act come into being over the coming years.

Mauri tū, mauri ora,

Shaun Robinson
Chief Executive

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About the Mental Health Foundation

The MHF's vision is for a society where all people flourish. We take a holistic approach to mental health and wellbeing, promoting what we know makes and keeps people mentally well and flourishing, including the reduction of stigma and discrimination (particularly on the basis of mental health status).

The MHF is committed to ensuring that Te Tiriti o Waitangi and its articles are honoured, enacted, upheld and incorporated into our work, including through our Māori Development Strategy. We are proud that Tā Mason Durie is a Foundation patron.

We take a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities; advocating for social inclusion for people experiencing distress; and driving population-wide positive mental health and wellbeing initiatives.

Our positive mental health programmes include Mental Health Awareness Week, Farmstrong (for farmers and growers), All Sorts (a national wellbeing promotion programme in response to COVID-19 and other natural disasters) and Pink Shirt Day (challenging bullying by developing positive school, workplace and community environments). Our campaigns reach tens of thousands of New Zealanders each week with information to support their wellbeing, and help guide them through distress and recovery.

We value the expertise of tāngata whaiora/people with lived experience of mental distress and incorporate these perspectives into all the work we do.

Established in 1977, the MHF is a charitable trust, and our work is funded through donations, grants and contract income, including from government.

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