Mental Health Foundation
OF NEW ZEALAND
mauri tū, mauri ora

Summary of recommendations for the Mental Health Bill

20 December 2024

Overarching recommendations

1. Note, and direct the Ministry of Health to consider and address, the implementation issues identified by the MHF throughout our submission.
2. Direct the Ministry and Health New Zealand to clearly demonstrate how and when “the system” will support the fundamental shifts needed to achieve a reduction in compulsory mental health care, including through the 2025 Mental Health and Wellbeing Strategy.
3. Direct the Ministry and Health New Zealand to prepare and publish a detailed implementation plan for the new Act to give government, Parliament and the public an assurance the system is prepared to administer the new law as intended.
4. A comprehensive programme of engagement with communities (such as lived experience and whānau networks) and the workforce about the changes in the Bill should take place as soon as possible after the Bill has passed, and should be provided in a range of accessible formats that are adequately disseminated/marketed for the best reach.
5. Divide the Bill into separate civil and forensic/restricted pathways to allow for the future merging of civil compulsory treatment processes into a “generic” capacity legislation.

Interpretation

6. “Patient” should be replaced with a term that better recognises people’s humanity and dignity.

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7. The title of the Bill should be changed, such as to the "Mental Distress (Compulsory Care) Bill" to reflect the Bill's scope and purpose more accurately.

8. "Tāngata whaiora" should not be used as a synonym or plural form for "patient/s". If "tāngata whaiora" is used in the Bill, its literal meaning and common interpretation (i.e., people seeking wellbeing when experiencing mental distress, addiction, and/or harm from gambling or substances) should be noted alongside its definition in the context of the Bill.

9. The obligation to uphold mana should be acknowledged in earlier compulsory care provisions (i.e., not just post hoc), such as in the compulsory care principles and in care planning.

10. Where the Bill qualifies an obligation with "if it is (reasonably) practicable", "wherever practicable" or "as practicable", this should be rephrased to make the obligation paramount unless the circumstances do not allow.

Te Tiriti o Waitangi

11. Add a standalone clause requiring the Bill to give effect to Te Tiriti o Waitangi or amend clause 5 to create a stronger directive to this end, such as by adding a preliminary subsection that first establishes that the Bill shall be interpreted and administered as to give effect to the principles of Te Tiriti o Waitangi.

12. Directly reference the articles or principles of Te Tiriti o Waitangi in the Bill, and how the law will provide for them.

13. Strengthen clause 3(b) to recognise the breadth of what is entailed by "mental health equity", including by amending the wording from "...by striving to eliminate mental health care disparities, in particular for Māori" to "...including by striving to eliminate mental health disparities, in particular for Māori".

14. Examinations and assessments to determine whether a person meets the compulsory care criteria should be conducted by multidisciplinary teams or

rōpū whaiora, rather than single practitioners, and include Māori practitioners if the person is Māori/if requested.

15. Applications for mental health care orders should be reviewed by Māori (ideally mana whenua), either in the Family Court framework provided for in the Bill, or via the tribunal framework recommended in the "mental health care orders" section of the MHF's submission.

16. The Bill should include a dedicated obligation to reduce the unacceptably high use of solitary confinement (seclusion) and other restrictive practices, restricted treatments and force on Māori (such as in clause 49 and 200 respectively), with corresponding practical actions that will give effect to this obligation. Provisions to this end could include, for example, a requirement to have kaumātua in every service, and 24-7 cultural support for tāngata whaiora, especially in contexts where solitary confinement (seclusion) is provided for.

17. Alongside whanaungatanga, the compulsory care principles should also support manaakitanga and wairuatanga.

18. The holistic assessment in the care plan could also recognise the strengths of whānau, hapū and iwi, either as its own subsection in clause 43(4)(a) or as part of clause 43(4)(a)(iv).

19. The Bill should more explicitly acknowledge which provisions might entail responsibilities for hapū and iwi, particularly in the "Tāngata whaiora rights and support" section (including the provisions for hui whaiora, advocates, and nominated persons).

20. The Health Committee should consider whether a person could be permitted to appoint more than one nominated person or a "nominated collective", to give better effect to tikanga Māori and collective decision-making.

Compulsory care principles

21. The Health Committee should seek expert advice on drafting options to give legal and practical effect to the human rights policy intent of the principles.

22. The "supportive and responsive application" principle should be amended to specifically recognise people's holistic needs.

23. The "supportive and responsive application" principle should recognise and support the unique needs and experiences of women and gender-diverse people.

Tāngata whaiora rights and support

24. The implementation plan for the new Act (noted at **Recommendation 3**) should address adequate support for the workforce to change practices, including by endorsing increased resourcing and growth, coordinating system-wide leadership to drive change, as well as adequate training and guidance for the workforce and other practical essentials to ensure decision-making supports are effective and available at all times.

25. There should be upfront investment, a sustained funding model, and infrastructure development to support the delivery of the Bill's supported decision-making roles, especially advocates. This should include consideration of the potential contribution of, and supporting infrastructure for, the tāngata mātau ā-wheako or CPSLE workforce.

26. The supported decision-making roles should be better delineated.

27. The Part 2 provisions should be made more proactive where possible, with sufficient obligations for people administering the Act to inform tāngata whaiora about, and provide, decision-making supports (such as advocates) at specific points in the compulsory care process (and repeatedly).

28. The provisions under Part 2 of the Bill should be available to people accessing voluntary mental health care, too.

Compulsory care directives

29. Primary, secondary and other voluntary mental health services should have a duty to inform people of their right to make a compulsory care directive, provide information about them, and ensure tāngata whaiora and their network are adequately supported to make or update one.

30. The Bill, or its secondary legislation, should specify the points (in the compulsory assessment and care process, such as upon release from compulsory status) at which tāngata whaiora are required to be informed of their right to make a compulsory care directive, and can be supported to make, update or revoke one.

31. Investigate the practicability of limiting who can be consulted about, and who can give assistance to make or revoke compulsory care directives to "mental health practitioners" only. We are concerned this could lead to bottlenecks, and the tāngata mātau ā-wheako or CPSLE workforce for example could also be ideally placed to walk tāngata whaiora through these processes.

32. Change the wording, at clause 12, from "preferences [i.e., regarding how and where method of care is provided, and involvement of support network] must be given effect to, to the extent that is reasonable/practicable" to "unless not reasonable/practicable".

33. Clarify the consequences of going against a compulsory care directive, and how this will be monitored. It could be noted here, for example, that a hui whaiora should be held after a compulsory care directive has been breached.

Hui whaiora

34. Consider lessons from Open Dialogue to inform hui whaiora and care planning processes.

35. Tāngata whaiora should have the option to opt out of hui whaiora if they wish.

36. Notes from hui whaiora should be recorded and agreed to collaboratively.

Support network

37. Consider strengthening the support network so it is involved more often and/or in more processes under the Bill.

38. Clause 18 should explicitly note that a person's support network can include roles for iwi, hapū and kaumātua.

Nominated person

39. Secondary legislation or other supporting material should provide adequate guidance for the nominated person and others in the support network (such as whānau) to fulfil their roles in accordance with supported decision-making principles, which should include, for example, how to handle disagreements and key concepts such as the "dignity of risk".

40. The Bill or secondary legislation should clarify the scope of the authority for the nominated person (or how this will be established in each case), including the decisions and/or decision-making processes nominated persons have dominion over, how nominated persons and compulsory care directives intersect or override each other, and what checks and balances will be provided to ensure nominated persons do not act outside their scope, or will be triggered if nominated persons are found to be acting against a person's will and preferences.

Advocate

41. Explore the appropriateness of an "opt-out" approach to access to advocates as seen in Victoria, Australia, so the onus is not on the individual to seek out advocacy services.

42. The powers of advocates, processes where they can be engaged, and practical mechanisms for procuring them should be made clearer.

43. Tāngata whaiora should have 24-7 access to advocates and this should be enshrined in the Bill. For example, clause 24(3) could be amended to read "Health New Zealand must ensure a reasonable number of advocates are available, such that all patients can access an advocate at any time".

44. Mandate in the Bill a Principal Advocate role to provide stewardship for advocate roles in services, with responsibilities to provide national coordination and leadership, and to support the development of guidelines, a code of practice, training and other infrastructure needed to support and maintain the successful roll-out of a new national advocacy workforce.

Whānau

45. The Bill should include a duty to provide access to support, information and advocacy for family and whānau, with parallel allocation of resources and funding to support its implementation.

Rights

46. Reference the CRPD in the Bill to serve as a guide for the interpretation of specific provisions by courts and statutory roles, to ensure interpretations are consistent with international principles (e.g., the right to equal recognition before the law and to legal capacity).

47. Consider an extension to "General rights to information" (cl 26(2)) to require the responsible practitioner to be satisfied the person has understood their rights – and if not, all reasonable steps were taken to assist them to understand.

48. "Right to respect for culture and identity" (cl 27) could explicitly include gender identity.

49. Consider an additional right to access to peer support, unless it is not practicable to do so (e.g., in the event of local peer support services being unavailable).

Compulsory care requirements

50. Consider, either in this Bill or in the five-yearly review, the benefits of sharing the "responsible practitioner" function across a care team or service.

51. Clarify how the lived experience role on the rōpū whaiora will be sourced.

Care planning

52. The responsible practitioner should provide the records of the initial care plan (i.e., as well as records of each care plan review and status review) with the tangata whaiora as well. This appears to be provided for by a judge at times, but the obligation for tāngata whaiora to receive records of their care plans could be made clearer. It will be equally important that these are developed and presented in a clear and understandable manner (including in the person's and their support network's primary language), with adequate time and support given to comprehend the information.

53. Care plans should take into account people's trauma-related needs. This could be achieved by amending clause 43(4)(a)(i) to "their mental health, physical health, and social needs, including in relation to any trauma experienced by the person".

Solitary confinement

54. Include a sunset clause for solitary confinement (seclusion) in the Bill, prohibiting its use after a specified time, such as within five to 10 years of the law coming into force.

55. Expand clause 49(1) so the obligation on "every person" to use their best endeavours to eliminate the placement of people in seclusion also applies to services.

56. Acknowledge in clause 49 that solitary confinement serves no therapeutic purpose and is traumatic and harmful to everyone involved.

57. Amend clause 121 to explicitly require the five-yearly review of the operation of the Act to report on solitary confinement, including frequency and length of use across facilities/regions, characteristics (including ethnicity) of those subjected to solitary confinement, and workforce capacity and capability trends and readiness for elimination.

ECT and restricted treatments

58. Require the Director of Mental Health to publish an up-to-date evidence brief for ECT every five years or sooner if necessary.

59. Amend clause 43 to explicitly require the care plan to address assessment and monitoring of physical health side effects for medications that pose significant risks, including through transition from tertiary to secondary and primary care.

60. The Bill's implementation should include strong monitoring arrangements for regulating chemical restraint and sedation, including by defining these terms and articulating the circumstances in which their use is permitted or restricted.

61. National data on the use of sedation should be included in Director's annual report.

Compulsory care assessment

62. Status reviews during the second assessment period, and while someone is under a mental health care order, should be conducted by the Mental Health Review Tribunal as a competent, independent and impartial legal authority. Mental health care orders

Mental health care orders

63. Given the evidence, consideration should be given to ending community mental health orders or introduce obligations to significantly reduce their use. This should be accompanied by investment in culturally appropriate, community-based acute and crisis services to provide genuine choice for people and whānau, alongside inpatient care.

Care plan and status reviews of persons subject to mental health care orders

64. Second and subsequent extensions should be reduced to six months as well, as this is more in line with a recovery approach.

Procedure for mental health care orders

65. Consider expanding the remit of the Mental Health Review Tribunal, or developing another tribunal-like process, to determine applications for mental health care orders.

Powers and offences

66. Consider requiring police to consult with health/social care professionals when deciding whether a person "meets the compulsory care criteria" and if it is "desirable in the interests of the person or of the public" to detain them and take them to hospital for assessment (cl 182). Ideally, police undertaking these tasks should be doing so as part of a multi-agency response.

67. National data on the use of force should be included in the Director's annual report.

Reporting

68. Amend clause 212 to require the Director-General to not only review the operation of the law, but to publish the review/recommendations within a reasonable timeframe, and require the Minister for responsible for mental health to table the review report and respond to its recommendations (with timeframes for legislative and service improvements) in the House of Representatives within a reasonable timeframe after receiving the report.