New Zealand
Psychological Society
Rōpū Mātai Hinengaro o Aotearoa

Submission on Mental Health Bill 2024

New Zealand Psychological Society

Submission prepared by:
NZ Psychological Society Executive
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Who we are

The New Zealand Psychological Society (NZPsS, "the Society") is the premier professional and scientific association for psychologists in Aotearoa/ New Zealand and is committed to supporting quality practice, education and research in psychology. The Society is making a submission on the Mental Health Bill due to our regular work related to mental health and its potential impact on our members.

The NZPsS represents over 2000 members and students and encompasses a broad range of practice in psychology in Aotearoa/New Zealand, including clinical, counselling, organisational and educational. We are committed to bicultural perspectives and practice and have substantial Māori representation on our decision-making bodies, including Executive, having recognised the significance of our partnership with Māori, consistent with Te Tiriti o Waitangi, through the establishment of a National Standing Committee on Bicultural Issues in 1991

The Society advocated for and, with other professional and regulatory bodies, established a new Code of Ethics in 2002 that strongly reflects our commitment to Te Tiriti and to principles relating to the pursuit of social justice and social wellbeing.

Overview of our submission

This Bill is a missed opportunity to legislate for a transformative and greatly improved mental health network that would provide effective supports when and as needed. We are concerned that there is still a focus on 'compulsory care' when this is inconsistent with international human rights and with what we know about supporting those with serious mental health impairment to improve.

We **support** the components of the Bill that enhance autonomy, supported decision-making, advance directives and clear opportunities for checks and balances.

We do **not** support the retention of seclusion as an option, compulsory care orders, or the ability for the individuals' wishes to be overridden.

We are concerned by the absence of appropriate alternatives to the biomedical solutions and absence of psychological models.

In the Society's previous submission on Transforming the Mental Health Act we highlighted several principles and considerations that are key to any review of the legislation. We revisit the relevant points below.

Components that we support in this Bill

Core principle/consideration: Patients/Clients should at all times be able to have an advocate of their choosing involved in their care – this may be whānau, friends, a therapist, or a patient advocate

> ***Relevance to this Bill:*** *This aspect is well provided for in the legislation and we appreciate the different options for support networks, independent support people and advocates, and the requirements for them to be consulted and kept informed about various aspects of the process.*

Core principle/consideration: Giving individuals more control over their treatment such as: the right to ask a second medical/health specialist to check their treatment plan and for this to be easily accessible; the right to ask for a tribunal/panel to review their treatment and release including safety risk assessment to self and others; and most importantly the right to an independent advocate unless they do not wish for such an advocate. This could be a person of their choosing such as a friend or family member, their own therapist, or a patient advocate.

> ***Relevance to this Bill****: There are clear rights and responsibilities outlined in the proposed legislation to ensure that individuals have a support person and/or advocate and that their personal support network is able to be involved in decisions and is given appropriate information about the processes being undertaken. The procedures also outline times where second opinions and panel review are required, as well as opportunities for individuals and their support network to request a second opinion or panel review.*

Components that we support in this Bill, with caveats

Core principle/consideration: Informed consent is integral to effective relationships which underpin all work with mental health issues. The Code of Ethics for psychologists in New Zealand requires that we only operate with informed consent of our clients. Whilst we recognise the need to ensure safety of individuals and others in the community, compulsory treatment goes against this requirement for informed consent.

If this is enabled in the act, all care should be given to minimise the situations in which it can be utilised

> ***Relevance to this Bill:*** *The use of advanced directives are a positive inclusion and offers the opportunity for some form of informed consent and supported decision making within a compulsory model. This should be the focus, around supporting individuals to receive the care they need and agree on. There are indications throughout the Bill that the proposed patient or patient should be given information about their care, and that their views should be taken into consideration – along with those of their support network or advocates.*
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> *However, in Section 43, the care plan itself, which will direct all the care does not need to be completed in consultation with the patient, nor does it need their consent. The Bill retains the option for practitioners to override the advanced directive, as well as the patient's wishes and proceed without their consent. This is non-compliant with internationally agreed human rights and the UN Convention on the Rights of People with Disabilities. Lack of consent can negatively impact on the therapeutic relationship and raises ethical questions.*
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> *The Bill also does not include any mechanisms to operationalise the supported decision-making that should be at the heart of this legislation. There are examples of these practices in action that could have been consulted for inclusion in the legislation – such as those being used by Te Kete Rongomau*[1].

Core principle: Complaints – the process to raise complaints needs to be easily accessible and issues raised by patients and whānau need to be followed up by an external body.

> ***Relevance to this Bill****: The Bill includes many opportunities for decisions and care to be reviewed by others which is beneficial and should help to ensure that decisions are carefully considered and that both the individual concerned and their support network are able to raise concerns when necessary.*
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> *However, there are also so many different roles and processes outlined, that it would be difficult to keep track of who is the right person to raise concerns with and when it is possible. Whilst written information is required to be provided this needs to be in multiple forms, including things like infographics or flowcharts, and people need to be reminded of this at multiple points in the process.*

Components that are absent from this Bill

Core principle/consideration: Legislation needs to support and enable Te Ao Māori models of care. It must acknowledge structural and institutional racism and put in place appropriate cultural supports. One example of an appropriate support would be

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[1] Lenagh-Glue J, Dawson J, Potiki J, O'Brien AJ, Thom K, Casey H, Glue P. Use of advance directives to promote supported decision-making in mental health care: Implications of international trends for reform in New Zealand. Aust N Z J Psychiatry. 2023 May;57(5):636-641. doi: 10.1177/00048674221079225. Epub 2022 Feb 15. PMID: 35164527.

cultural assessments for Māori which contribute to meaningful treatment plans. Understanding and awareness of cultural norms within different cultures is imperative in any assessments of capacity and/or illness

> ***Relevance to this Bill**: The legislation is very heavily focussed within a Western biomedical model of care, with a focus on hospital admission for compulsory 'inpatient' care – noted in Section 70. There is the option for Community Care, but this is not well defined. If compulsory inpatient care is going to be an option under this legislation then it should not be restricted to a hospital setting. Alternative residential care that can appropriately meet cultural needs, whilst also providing the necessary therapeutic benefits and protections, should be explicitly allowed for under this legislation.*
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> *There is no requirement in the first or second assessment to consider cultural norms or for the mental health practitioner conducting the assessment to be experienced in this area. This is a significant failing of the Bill and must be amended.*

Core principle/consideration: Concerns over a highly medicalised model being implemented when a more holistic approach is beneficial to improving outcomes. We support the use of non-medical personnel in the assessment and treatment of clients. Psychologists are under-utilised within these areas currently and offer a more holistic perspective to support clients and their health. Cultural input is also necessary when considering a client's symptoms, risk and appropriate treatment

> ***Relevance to this Bill:** As noted above the models described within the legislation are very medicalised - from the use of the word 'patient' to describe the individual at the centre of these processes, to the focus on medical practitioners and nurses providing the care or making decisions, and hospitals as the default for more intensive care needs.*
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> *The legislation makes a step towards a more holistic approach with the requirement for a rōpū whaiora, which enables the involvement of a wider group of people with appropriate skills to support the individual.*
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> *However, this could be significantly expanded to enable the use of different skilled professionals, such as registered psychologists within the definition of "Mental Health Practitioner" and/or "Responsible Practitioner". Currently it is possible that medical practitioners and nurses with little to no experience in mental health are able to make decisions about a person's level of mental health impairment, whilst a psychologist- with significant training in this area - is not able to make such assessments.*

Core principle/consideration: Resourcing for community-based initiatives to enable earlier, timely, proactive, effective care to reduce or eliminate the need for compulsory treatment.

> ***Relevance to this Bill****: With the current format of the Bill this type of initiative or resourcing is not considered. However, if the opportunity was taken to make a positive transformation of the mental health system, instead of tweaking the status quo, we reiterate the need for appropriate commissioning and resourcing to enable effective, culturally appropriate, affordable care options for those with mental distress in order to avoid the need for compulsory care.*

Core principle/consideration: Right of individuals to continue to refuse medication or aspects of treatment, even if under a compulsory order - maintaining the right to refuse medication and other treatment options, if compulsory treatment is enacted. For example, if they are compelled to be in a treatment unit, they can still refuse a medication, or to participate in certain activities.

> ***to this Bill****: We are highly concerned that this component is not included in the current Bill. Individuals should continue to have the right to refuse treatments even when under a compulsory order – at the very least when there is a clinically appropriate alternative available. They also should have the right to refuse other treatments or medical care (unrelated to the mental health issues they are being required to receive care for). This is not included in the rights of patients outlined in clause 25-38.*

Further Comments on the Proposed Legislation

Section 49: Seclusion: We are concerned that seclusion is still an option within this legislation. We recommend that this have a "sunset" clause, giving services time to adapt and find alternative methods of working with individuals but ultimately ending this practice in Aotearoa.

We do support the intent to eliminate the use of this practice and that it is not allowed for those under 18.

Within the current clause the following change is recommended:

i. Should be added that a report on each incident of seclusion is sent to the patient's support network, district inspector, official visitor, independent support person and/or advocate in line with other reports and notifications in this Bill.

Section 16 (3): Requirement to provide interpreter is mitigated by the phrase "if it is practicable to do so": Whilst we recognise that this is included to allow for situations where no interpreter is available, it also makes it very easy for the court, tribunal, or person responsible to claim that no interpreter was available, when in fact they did not make much of an effort to find one. Without an interpreter, or some way of ensuring that the individual is able to understand what is happening they are unable to give informed consent or provide appropriate responses to questions. This severely impacts their rights and autonomy under this legislation.

Section 23 and 24: Definition of Independent Support Person and Advocate: Given colloquial use of these terms it is important that it is clear who can hold these roles. It appears from sections 23 and 24 that these are intended to be individuals who hold these roles officially – e.g are employed to do this type of work. It should be made clear if they can be held by someone an individual (patient or proposed patient) knows personally and who is volunteering to do this to support them.

Section 28: Rights to Medical and other Health Care: this section on Rights to Medical and other health care does not apply to voluntary patients and it is unclear why they would not have a right to receive medical and other health care as required. Voluntary patients, seeking mental health care still need to have their medical and other health care needs met. Whilst they are able to leave at any time, there will be many circumstances where medical care needs to be provided whilst they are also receiving mental health care. For example patients who need access to insulin for diabetes management, or when a physical accident occurs and they need medical treatment. Mental health care providers have been known to withhold or threaten to withhold necessary medical care and as such even voluntary patients should have this care as a right.

Section 33 (1): Entitled to be informed about video recording etc: Concern about the wording and timing. 'Entitled' infers they will only be told if they ask about it. This clause would be better worded as 'must be informed.' Consent is required in subsection (2) but is not required to be sought at the time of the recording. With current wording services could seek general consent at the beginning or some other time and then recording happens at a point in which the individual does not agree. We also suggest that you add a right to request recording is destroyed.

Section 35(2): Provides that specific communications cannot be withheld from individual: This clause is intended to ensure that an individual is able to communicate freely with their Member of Parliament, a Judge, lawyer, etc. However, this does not allow for the situation in which someone in one of those roles is abusive or threatening to the individual and they do not wish to receive these communications. The current proposal means these must be given to the individual. Wording should be altered to reflect that communications cannot be withheld unless requested by the individual.

Section 56: Mental health practitioner or clinical psychologist can do initial examination: We support the inclusion of clinical psychologists in this section to do an initial examination to assess reasonable grounds for meeting the compulsory care criteria, however we would include any registered psychologist as psychologists from different scopes would also have the competency to undertake these initial assessments.

We also support registered psychologists being included in the mental health practitioners in Section 57 who can undertake the first assessment.

Section 77 (4): Court can suspend or modify welfare guardian if it thinks fit: It is concerning that where an individual has a welfare guardian in place this can be overruled by the court in relation to their care under this legislation. This section should be removed.

Section 77 (5): Copy of the order only to patient: It is inconsistent with previous parts of the legislation that the court only has to provide copy of mental health care order to patient, when those acting under the legislation have to provide previous reports and decisions to multiple people including the person’s support network, advocate etc. The mental health care order should be supplied to the individual, but also to those who are supporting them.

Section 86: Extensions of the order: This section enables the order to be extended indefinitely, albeit in chunks of 6 months and then 12 months. It should never be necessary for this type of compulsory care to be extended indefinitely.

Section 17 (4): Hui Whaiora: Rather than needing to repeat the definition after Hui whaiora each time – provide the definition in the interpretation. If not doing this, need to review this section for consistency as you repeat the English version after many instances but not all.