Legislative Statement: Mental Health Bill

This legislative statement is presented to the House in accordance with Standing Order 272.

Overview

1. This legislative statement supports the first reading of the Mental Health Bill.
2. The Mental Health Bill (the Bill) will repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). The Bill sets out the circumstances under which a person can be provided mental health care without their consent. The Bill modernises how compulsory mental health care is provided in New Zealand to a more rights-based and recovery approach.
3. In summary, the Bill:
    a. states its purpose, how it gives effect to the principles of the Treaty of Waitangi and provides for compulsory care principles to guide decision-making
    b. sets out the compulsory care criteria that must be met before a person can be subject to compulsory mental health care
    c. provides for supported decision-making, including compulsory care directives, duties on specified persons to encourage participation, hui whaiora (well-being meeting), nominated persons as well as independent support and advocates
    d. sets out the rights of those subject to compulsory mental health care and the process for making complaints
    e. sets out specific rights for children and young people
    f. updates the processes for the assessment and care of patients
    g. sets out the aim to reduce and eventually eliminate restricted practices
    h. provides for the care of people who enter through the justice system
    i. sets out how the provision of compulsory mental health care will be administered, monitored, and reported on.

Foundations for person-centred care

4. Part 1 of the Bill sets out the foundations for how compulsory mental health care is to be provided. This includes the Bill's purpose, how it gives effect to the principles of the Treaty of Waitangi and decision-making principles.
5. The purpose of the Bill is to provide for compulsory mental health care in a manner that:
    a. promotes decision-making capacity
    b. improves equity in mental health outcomes among New Zealand's population groups
    c. protects the rights of tāngata whaiora[1]

[1] The Bill defines tāngata whaiora as people with lived experience of mental distress. It is intended that this is inclusive of all people who experience mental distress or substance harm who have or are seeking wellness or recovery. It recognises that even if a person is receiving compulsory care there can still be wellness within them. People with lived experience generally prefer this term over 'patient', 'service user' and 'consumer'.

d. protects the safety and wellbeing of tāngata whaiora and all other New Zealanders

6. The provisions in the Bill that provide for the Crown's intention to give effect to the principles of the Treaty are sign-posted in clause 5. These provisions include the purpose, principles, involvement of whānau, the right to proper respect for a person's cultural, ethnic and individual identity, and holistic care planning.

7. The compulsory care principles set out in clause 6 apply to courts, tribunals and people undertaking functions, powers and duties under the legislation. The intent of the principles is that compulsory care should:

   a. serve a therapeutic purpose and only be used to protect, promote and improve a person's mental health
   b. be applied in the least restrictive manner by ensuring voluntary options are actively offered and that compulsory care should be applied for no longer than is reasonably necessary
   c. be provided in a supportive and responsive way by seeking to encourage capacity and choice and by reflecting the needs of the person.

Compulsory care criteria

8. Part 1 of the Bill also sets out the criteria under which a person may be subject to compulsory care. The criteria will be met if:

   a. a person has seriously impaired mental health
   b. that causes or is likely to cause serious adverse effects, and
   c. that causes the person to lack decision-making capacity in relation to their mental health care.

9. The three criteria are further defined to assist decision-makers assessing people against them. Seriously impaired mental health is defined similarly to the 'abnormal state of mind' criterion in the Mental Health Act. Serious adverse effects include serious physical or psychological harm or serious deterioration in a person's health. The capacity test reflects capacity assessment undertaken under other legislation and the common law.

10. The compulsory care criteria are intended to ensure compulsory care is only given when it is justified. A person with seriously impaired mental health will not be compelled to receive care unless they cannot make decisions and serious harm has, or is likely to, occur.

Supported decision-making and family and whānau involvement

11. Part 2 of the Bill introduces a range of supported decision-making provisions that will ensure people can make their own decisions wherever possible either in advance of requiring compulsory care or when they are subject to their legislation. These include:

   a. the ability for people to make compulsory care directives about any future compulsory care
   b. provision for the appointment of a nominated person to represent a person's interests should they become subject to the Bill

c. the inclusion of independent support people and advocates to assist and support patients to exercise their rights and participate in decision-making
d. the introduction of hui whaiora (well-being meeting) to provide an additional avenue to bring together the person, their support network (which includes family and whānau) and other professionals involved in their care to support decisions about a person's care, resolve issues, disputes or complaints and support restorative practices
e. the introduction of participation requirements to ensure patients are encouraged and assisted to participate in decisions being made about them.

Rights and complaints

12. Part 2 of the Bill also updates the rights of those subject to compulsory care and clarifies who must uphold them. Relevant rights are also extended to voluntary inpatients, allowing them to access the complaints processes in the Bill.

13. Patients will have the right to:

a. general information
b. respect for culture and identity
c. medical and other health care
d. be informed about medical and other health care
e. independent health advice
f. legal advice
g. company
h. be informed about and refuse consent to any visual or audio recording of them
i. receive visitors and communicate with others
j. send and receive communications
k. communication aid
l. mobility aid.

14. Part 2 of the Bill also sets out specific rights for children and young people. Patients under 18 must wherever practicable be cared for by child and adolescent mental health services, and must not be placed in seclusion or given a restricted treatment. They must also not be given electroconvulsive therapy except in an emergency.

15. Clause 39 of the Bill sets out a complaints process for when a patient, or someone on their behalf, considers a right under the Bill has been breached or detention or care has not been provided in accordance with the legislation.

16. Complaints must be referred to a district inspector or official visitor for investigation. If, following their investigation, the district inspector or official visitor considers the complaint has substance, they must report the matter to the Director of Area Mental Health Services together with any recommendations they think fit. The Director of Area Mental Health Services must take all reasonable steps to rectify the matter.[2]

[2] See 'Administration, monitoring and reporting' section below for information about roles and responsibilities

Providing compulsory care

17. Subpart 1 of part three of the Bill sets out how care is to be provided. All patients will have a responsible practitioner who must ensure an appropriately qualified rōpū whaiora (collaborative care team) is set up to support the provision of care. The Bill requires the responsible practitioner to ensure a patient has a recorded care plan that is kept under review and updated as required. The care plan must include a holistic assessment of the person, care options (including non-pharmaceutical options), and transition planning to help prepare the person once they are no longer subject to the legislation.

18. Compulsory care can only be directed if it aligns with the patient's care plan or in an emergency. A patient's support network must be given reasonable opportunity to contribute to care planning and express their views on the patient's condition and care.

19. The Bill places additional limits on some kinds of treatment including electroconvulsive therapy and any treatment intended to destroy any part of the brain or brain function. Electroconvulsive therapy can only be provided if the patient consents or, if the patient does not have capacity to make decisions about mental health care, an independent mental health practitioner considers it in the interests of the patient. It can only be provided to those under 18 in an emergency.

Reduction and elimination of seclusion

20. The Bill requires every person performing a function under it to use their best endeavours to eliminate seclusion. There are a number of limits on when a person can be placed in seclusion to support this aim, such as that it must be used only for as long as necessary to ensure the safety of people and only to prevent imminent risk to life. No one under 18 years can be placed in seclusion.

21. The Bill includes a regulation-making power which allows regulations to prohibit or restrict the use of seclusion.

Processes for determining if a person should be subject to compulsory care

22. Subpart 2 of Part 3 of the Bill sets out the process for how a person can be subject to compulsory care. The process has been updated to simplify the steps and to include the input of a broader range of professionals and expertise. The process consists of an application for first assessment, a first assessment (up to 6 hours), a second assessment (up to 19 days), an application for a mental health care order and a mental health care order (6 or 12 months and either inpatient or in the community).

23. Each step in the process requires the decision-maker (either a mental health practitioner or the Family Court) to assess the person against the compulsory care criteria, taking into account the compulsory care principles, the patient's care plan and input from the patient and their support network. If at any time the patient no longer meets the compulsory care criteria, they must be immediately released.

24. Once on a mental health care order, a patient must have a care plan review every month and a status review every 3 months (or sooner if the responsible practitioner considers the condition of the patient has changed). A patient or their support network can apply to the Mental Health Review Tribunal for a review of their condition if they disagree with the outcome of the status review.

Forensic patients

25. Part 4 of the Bill sets out the provision of compulsory mental health care for certain people in the criminal justice system. 'Forensic patient' status is conferred on people who are detained in a hospital following an order under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP) Act) or transferred from a prison. Forensic patients will include:

    a. defendants found not criminally responsible on account of insanity
    b. defendants who are unfit to stand trial
    c. people charged with, or convicted of, a criminal offence and remanded to a hospital for a psychiatric report
    d. people who have been convicted of a criminal offence and both sentenced to a term of imprisonment and placed under a compulsory treatment order
    e. remanded or sentenced prisoners transferred from prison to a hospital for mental health care.

26. Forensic patients are intended to be treated like other recipients of compulsory mental health care with the same access to services to meet their needs and rights under the legislation. However, the entry and exit criteria for patients who are subject to compulsory care under the CP(MIP) Act will continue to be as provided for in the CP(MIP) Act. These forensic patients will not automatically be released if they do not meet the compulsory care criteria. Instead, decision-makers will need to be satisfied that continued detention is no longer necessary to safeguard the forensic patient's interests as well as the safety of others and the general public.

27. Decisions about long leave, change of status or discharge of forensic patients will be changed from the Minister of Health to a Forensic Patient Review Tribunal. This will improve procedural fairness for patients who do not have an opportunity to be heard in the existing process. The Attorney-General's role in decisions about change of legal status for forensic patients found unfit to stand trial will not be changed.

Restricted patients

28. Part 4 of the Bill sets out that the court, on application by the Director of Mental Health, can make an order declaring a patient presenting 'special difficulties' to be a restricted patient. 'Special difficulties' is defined as meaning the patient poses an unacceptable risk of seriously endangering the physical or psychological safety of another person.

29. Restricted patients are subject to more stringent leave and release provisions similar to forensic patients. The intent of declaring a patient to be a restricted patient is to manage significant safety issues that cannot be managed on an inpatient or community care order.

Administration, monitoring and reporting

30. Part 6 of the Bill sets out a range of roles with responsibilities for administering and monitoring the legislation and reporting requirements. Key roles set out in the Bill will include:

    a. a Director of Mental Health – appointed by the Director-General of Health and responsible for the general administration of the Bill and for publishing an annual report
    b. a Deputy Director of Mental Health – appointed by the Director-General and responsible for any functions and duties of the Director that the Director may require
    c. Directors of Area Mental Health Services (DAMHS) – appointed by the Director-General and responsible for oversight at the service or facility level and required to regularly report to the Director of Mental Health
    d. authorised persons – authorised by the DAMHS and responsible for helping people in need of compulsory assessment and care
    e. district inspectors – lawyers appointed by the responsible Minister and responsible for independent monitoring and oversight and ensuring people subject to compulsory care are advised of their rights, complaints are investigated, and services are improved if required
    f. official visitors – appointed by the Minister and responsible for similar things as district inspectors but do not have to be lawyers.

31. The Bill enables the appointment of a Mental Health Review Tribunal with up to four members including a lawyer and a suitably qualified mental health practitioner. The principal function of the Mental Health Review Tribunal is to consider the condition of a patient who has applied for a review.

32. The Bill also enables the appointment of a Forensic Patient Review Tribunal with up to four members, including a lawyer and a suitably qualified mental health practitioner with expertise in forensic mental health. The principal functions of the Forensic Patient Review Tribunal are to determine leave applications, review the condition of forensic patients and determine applications for change of status under the CP(MIP) Act.

Other provisions

33. Part 7 of the Bill sets out powers in relation to taking people to appropriate places for assessment and care or when urgent assistance is required. It also sets out offences and penalties.

34. Part 8 of the Bill contains miscellaneous provisions such as powers to make secondary legislation or prescribe forms, and requirements to keep certain information and undertake reporting, such as the Director of Mental Health's annual report. The Bill must also be reviewed every 5 years.