The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

Health Committee

Mental Health Bill

December 2024

Improve the mental health of our communities

PO Box 10669 Wellington 6143 New Zealand
T +64 (0)4 472 7247 F +64 (0)4 472 7246
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

Royal Australian and New Zealand College of Psychiatrists submission

Mental Health Bill

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances mental health practice, and advocates for people affected by addiction, or other mental health difficulties. The RANZCP represents more than 8400 members, including more than 5900 qualified psychiatrists and 2400 trainees across Aotearoa New Zealand and Australia. We are guided on policy matters by a range of expert committees made up of psychiatrists and community members with a breadth of academic, clinical, and service delivery expertise in mental health and addiction.

Introduction

Tu Te Akaaka Roa, the Aotearoa New Zealand National Committee of the RANZCP, welcomes the opportunity to provide feedback on the Mental Health Bill (the Bill) as part of the Select Committee's public consultation. The recommendations contained within this submission have been made in consultation with Aotearoa New Zealand based members of the RANZCP who offer vast and varied experience working in mental health and addictions.

This submission does not provide comment on Part 4 of the Bill. Recommendations regarding compulsory mental health care for forensic and restricted patients have been provided separately in consultation with the Aotearoa New Zealand Faculty of Forensic Psychiatry.

Key Messages

Based on expert advice from Aotearoa New Zealand-based psychiatrists and lived experience representative, Tu Te Akaaka Roa recommends:

- Removing section 8(2)(j) and section 8(2)(k),
- Changing s(7)(c) to consider lack of capacity, regardless of cause,
- Setting a specific standard for those approved to complete the first assessment, to ensure those mental health practitioners have a particularly high level of knowledge and experience, understanding of cognition, mental health, medio-legal principles, and ethics,
- The first assessment be completed as soon as practicable and after no longer than 16 hours,
- Adding a further supported decision-making provision, mirroring Right 7(4) of the HDC Code of Rights,
- Seclusion of those under the age of 18 be subject to section 49 of the Bill,
- Adding provisions to ensure the safety and wellbeing of the child and parent-infant bond for tāngata whai ora within the perinatal period,
- Responsibility to provide an appropriately qualified and experienced rōpū whaiora (collaborative care team) lie with Te Whatu Ora | Health NZ,
- Full costing by Treasury and mental health funding increases in line with this costing.

Recommendations

Compulsory Care Criteria

Tu Te Akaaka Roa does not oppose the compulsory care criteria. However, we recommend changes to the exclusion criteria to ensure the Bill is fit for purpose, and appropriately supports high-quality clinical care for all tāngata whai ora in need of compulsory care.

Tāngata whai ora with a seriously impaired mental state resulting from 'neurological or other brain diseases' or 'primary physical illnesses' are excluded from receiving treatment under the Bill, in its

current form. We disagree with these exclusions (s8(2)(j) and s8(2)(k)), which are discriminative, reinforce stigma and prevent essential care for a range of people where such statutory coverage is critical. [1]

It is generally accepted that mental health challenges arise from a combination of biological, psychological, and environmental factors which cannot easily be separated. With the emergence of new biomarkers, some practitioners now conceptualise several psychiatric disorders, including Schizophrenia and Bipolar Disorder, as brain diseases. [2, 3] Similarly, several neurological disorder or primary physical illnesses, including delirium, dementias, Huntington's Disease, or encephalitis, are associated with severe mental health challenges, often accompanied with a loss of decision-making capacity. The general medical environment is often unable to provide adequate care for tāngata whai ora experiencing these conditions and we believe they have a right to the same care and protection as any other New Zealander.

> **Recommendations**
>
> We recommend that Section 8(2)(j) and section 8(2)(k) be removed from the legislation and s(7)(c) be changed to 'the person lacks capacity to make decisions about their mental health care'.

Qualifications of mental health practitioners for the first assessment

Under the Bill, compulsory care assessments can be conducted by a wide range of clinicians, including medical practitioners, nurse practitioners, registered nurses practising in mental health, and any other person or class of person appointed by the Director of Mental Health under section 149. In the context of significant workforce shortages, we are generally supportive of broadening the scope of professionals able to complete assessments under the Bill. However, we are concerned that the Bill does not set a minimum standard for qualifications required, particularly for completing the first assessment. While each stage of the compulsory assessment process and care planning is important, the first assessment marks the initial point at which a person's liberty may be substantial restricted and coercive interventions may be initiated. Therefore, we consider it particularly important to have robust and highly qualified health professionals conducting these assessments.

Assessors are required to make complex decisions in in line with the legislation, including the compulsory care principles, historical and cross-sectional information, cultural consideration, and the views of whānau whai ora. The risk between restricting someone's autonomy unnecessarily and the potential of the person's impaired mental health causing harm to self or others must be carefully balanced which requires a high level of knowledge and experience in mental health, cognition, medio-legal principles, cultural safety, and ethics.

> **Recommendation**
>
> We recommend that clinicians conducting the first assessment have an additional requirement, beyond meeting the Bill's mental health practitioner criteria. That is, that they are a person or class of persons with a particularly high level of knowledge, training, skills, and experience specifically approved to conduct the first assessment by the Office of Director of Mental Health.

Assessment Process

Section 188 of the Bill authorises admission and detainment in hospital for up to six hours for the purpose of completing the first assessment. While this is in line with current legislation, we believe the

additional requirements under the Bill necessitate an extension of the timeframe. Decision-making capacity is complex, and assessments require a nuanced approach, particularly where tāngata whai ora are in an acute state of distress or intoxicated. Completing such assessments in addition to a mental health risk assessment, and seeking input from the proposed patient's support network, within a six hour window (and potentially overnight) may be challenging, and in some cases, impossible to achieve.

Providing additional time for tāngata whai ora to be held in a safe environment prior to the completion of the first assessment may also allow for non-continuation and prevent overly restrictive measures being put in place for the second assessment period.

> **Recommendation**
>
> Tu Te Akaaka Roa recommends the first assessment be completed as soon as practicable, and no longer than 16 hours.

Supported Decision-making

The Tu Te Akaaka Roa supports the provision of the decision-making structures outlined in the Bill. While the Bill falls short of meeting United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) requirements, provisions such as advocacy roles and hui whaiora, are strong steps in the right direction and allow for whānau to be part of mental health care planning and decision-making.

The UNCRPD aims to protect the rights of persons in psychosocial distress and ensure they are supported to make their own choices, or decide collectively with their whānau, wherever possible. While the addition of the capacity criterion, compulsory care principles, and supported decision-making structures aim to affirm this intention, we are concerned that in many cases, decision-making will be substituted due to procedural issues and resource constraints. The Bill is currently missing adequate provisions to ensure the focus is on providing culturally appropriate clinical care, within the context of the person's psychosocial circumstances.

> **Recommendation**
>
> Tu Te Akaaka Roa recommends that the Bill adds a provision, mirroring Right 7(4) of the Health and Disability Commissioner Code of Rights: Where a person has diminished capacity, that person retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of capacity. Provision of services should be consistent with the informed choice the person would reasonably be expected to make if they had capacity. In situations where tāngata whai ora do not have access to support from family or whānau, social and cultural suitability of a decision-making supporter must be taken into consideration.

Seclusion and Restricted Treatments

As outlined in Position Statement #61, the RANZCP is committed to minimising and, where possible, eliminating the use of seclusion and restraint. Any use of seclusion and restraint can reduce autonomy, mana, and dignity and be inherently traumatising for the individual, their family, whānau, and staff. The RANZCP advocate for alternative models and strategies which move towards de-escalation to improve safe practice and promote optimal outcomes to tāngata whai ora.

However, legislative change alone will not deliver system improvement. Chronic underfunding of Aotearoa New Zealand's mental health and addiction services has resulted in inadequate facilities and critical workforce shortages. These shortcomings are evident in reports of inappropriate use of seclusion, lack of clinical oversight. [4] System changes and appropriate resources need to be provided before legislative changes come into place, to avoid inadvertent consequences, such as increased use of

inappropriate restrictive practices, harm to tāngata whai ora or staff, and/or non-reporting of these practices.

The Bill acknowledges current system constraints and the risks associated with banning seclusion, yet it prohibits its use for whai ora under the age of 18. Tu Te Akaaka Roa is concerned that, unless sufficient resources and supports are provided, a premature ban of seclusion will create unnecessary risk for tāngata whai ora under the age of 18. Instead, we recommend the development of relevant guidelines to specify safeguards, procedure, approvals, and reporting requirement for extreme circumstances where tāngata whai ora under 18 require seclusion.

We highlight that seclusion must only be used as a last resort and very short-term measure in consultation with relevant experts. Where seclusion of tāngata whai ora Māori is required, guidance from kaumatua, kaimahi Māori, or a practitioner with expertise in Tikanga must be sought.

Recommendations

Tu Te Akaaka Roa recommends seclusion of those under the age of 18 be subject to section 49 of the Bill, which outlines provisions for the reduction and elimination of seclusion. This allows for specific guidelines to be provided for children and young people under the age of 18 and a systematic approach towards elimination of seclusion while maintaining safety measures while the system is undergoing the necessary changes.

The practice of cultural safety is essential to ensure that such approaches are effective for all people and to challenge the role of cultural bias and institutional racism in the use of seclusion and restraint. Where seclusion involves tangata Māori, guidance from kaumatua, kaimahi Māori, or a practitioner with expertise in Tikanga should be provided wherever possible.

Compulsory care for primary caregivers

The perinatal period (generally from conception for up to 2-3 years postpartum) is a time of upheaval and risk of recurrence of pre-existing mental health conditions as well as the onset of new episodes. [5, 6] Poor parental mental health and stress can have significant impacts on the wellbeing and mental health of their children, particularly during the perinatal period when attachment is formed.

In situations where a parent requires care under the Bill, it is important to consider the needs of both the (proposed) patient and their child, taking into consideration the specific issue/s, appropriate interventions, and the evidence base for improving parenting and/or the quality of the parent-child relationship. Research evidence has shown improved outcomes for whānau who are able to access specialist perinatal mental health services; if inpatient mental health care is required in late pregnancy or the first 12 months postpartum, joint parent and baby admissions is advised. [5, 6]

Recommendation

We recommend the Bill make provisions to ensure the safety and wellbeing of the child, the impact on whānau and the parent-infant relationship is considered as part of mental health assessments and care planning under this Bill. Wherever possible, care should be provided by perinatal mental health services. When hospitalisation is required during the first 12 months postpartum, pēpi should be admitted together with their primary caregiver.

Responsible practitioners

Section 42 of the Bill requires the responsible practitioner to ensure that a patient has an appropriately qualified and experienced rōpū whaiora (collaborative care team). While we support the provision of a

suitable rōpū whaiora in principle, we believe this is unlikely to be achieved, unless public funding for mental health and addiction services and workforce is increased substantially within the next two years.

As mentioned previously, Aotearoa New Zealand's mental health and addiction system is severely under resourced; workforce shortages remain critical across the motu with vacancy rates of up to 30% for psychiatrists and senior medical officers, and increasing turnover rates. [7, 8] Recent data released under the Official Information Act showed that more than 100 individuals under compulsory mental health treatment orders did not currently have a responsible clinician, as required by legislation. Provision of an appropriately skilled and experienced rōpū whaiora can only be ensure if appropriate resources are made available. Given individual treatment providers seldom have substantial influence over resource allocation and hiring practice, responsibility must not lie with responsible practitioners.

Recommendation

We recommend the responsibility to provide an appropriately qualified and experienced rōpū whaiora (collaborative care team) lie with Te Whatu Ora | Health NZ.

Resource implications

The resources required to implement the new law must be carefully considered. We believe the Bill will have substantial resource implications, including increased costs associated with:

- Supported decision-making processes and structures and reporting requirements. We expect the introduction of these processes to increase the workload for both clinical and non-clinical staff, requiring additional frontline staff and administrative support. The Bill also requires Te Whatu Ora | Health NZ to ensure whānau whai ora have access to independent support persons and advocates which will likely have significant budgetary implications.
- Workforce training and support, such as the development of relevant guidelines and cultural safety and competency training. Given the requirement for the completion of capacity assessments and the broadened scope of assessors, additional resources must be allocated to the development of appropriate standards and provision of equitable workforce training.
- Educational resources for tāngata whai ora and whānau to ensure New Zealanders are aware of their new rights and how to access decision-making support structures, such as compulsory care directives, nominated persons, and advocates.
- Physical and digital infrastructure. As mentioned previously, many mental health facilities in Aotearoa New Zealand are not fit for purpose and additional resources must be provided to ensure appropriate facilities and safe spaces are available to complete the required assessments and hold hui whaiora. To ensure effective and secure management of compulsory care directives and other supported decision-making structures, and streamline reporting, health sector data and digital systems require a substantial upgrade and nationwide coordination.
- Development of kaupapa Māori services that allow for culturally appropriate assessments and whānau-centred care, including co-design with iwi and Māori mental health professionals.

Without the provision of adequate resources, the processes set out within the Bill will be unattainable. Diversion of resources may create a two-tiered mental health system whereby those under the Bill get good access to care, at the expense of those who are not under the Bill's provisions. This would not only create pressure for people to be under the Bill in order to access treatment, but also increase the risk of coercive treatments and may cause harm to both patients and clinicians.

Recommendation

Given the substantial resource implications of the Bill, Tu Te Akaaka Roa recommends the Bill undergoes full costing by Treasury and that mental health funding is increased in line with this costing.

Thank you for the opportunity to provide feedback on the Mental Health Bill. We would welcome the opportunity to engage further with the Health Committee to ensure the Bill improves safety and equity in mental health outcomes for all New Zealanders.

References

1. Latoo J, Mistry M, Alabdulla M, Wadoo O, Jan F, Munshi T, et al. Mental health stigma: the role of dualism, uncertainty, causation and treatability. General psychiatry. 2021;34(4).
2. Juang R, Li C, Harris RB, Paine S-J. Caregiver experiences of racism and child mental health outcomes: cross-sectional analysis from Aotearoa New Zealand. N Z Med J [Internet]. 2023 2023/08//; 136(1581):[28-43 pp.]. Available from: http://europepmc.org/abstract/MED/37619225.
3. Harrison PJ, Geddes JR, Tunbridge EM. The emerging neurobiology of bipolar disorder. Trends in neurosciences. 2018;41(1):18-30.
4. Ora TAW. Ki te Whaiao - Kaupapa Māori Approaches to Mental Health Care. 2024.
5. Excellence CoP. Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. 2017.
6. Psychiatrists RAaNZCo. Position Statement #57: Perinatal mental health services. 2021.
7. Pou T. Te Whatu Ora adult mental health & addiction workforce estimates, 2023. 2024.
8. Pou T. Te Whatu Ora adult mental health and addiction workforce: 2022 alcohol and drug, forensic, and mental health services. 2023.