New Zealand Law Society
Te Kāhui Ture o Aotearoa

Mental Health Bill

Submission of the New Zealand Law Society Te Kāhui Ture o Aotearoa

20 December 2024

1 Introduction

1.1 The New Zealand Law Society Te Kāhui Ture o Aotearoa (**Law Society**) welcomes the opportunity to comment on the Mental Health Bill (**Bill**). The Bill proposes to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (**MHA**) to create a modern legislative framework for compulsory mental health care.

1.2 This submission has been prepared by the Law Society's Family Law Section with input from the Health and Disability Law Committee, whose members actively practise in this area of law.[1]

1.3 The Law Society **wishes to be heard** on this submission.

2 General comments

2.1 The Law Society supports the repeal of the MHA and its replacement with new legislation to provide for compulsory mental health assessment and care in a manner that:

(a) promotes a person's decision-making capacity;

(b) improves equity in mental health outcomes;

(c) protects people's rights under the legislation; and

(d) protects the safety and well-being of people who are subject to the legislation.

2.2 The changes proposed by the Bill are important. They will improve the human rights consistency of New Zealand's legislation compared to the MHA. The Bill affects human rights which are covered in a number of international treaties that New Zealand has ratified — including the Convention Against Torture (**CAT**); Convention on the Rights of the Child; International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights; and the Convention on the Rights of Persons with Disabilities (**UNCRPD**). The Mandela Rules, Universal Declaration of Human Rights and the United Nations Declaration on the Rights of Indigenous Peoples are also pertinent. The Bill affects a number of rights in the New Zealand Bill of Rights Act 1990 (**Bill of Rights**), as discussed in advice on the Bill provided by the Ministry of Justice.[2] Any limitations on those protected rights must be demonstrably justified, meaning that they must meet a sufficiently important objective and be proportionate to the aims the Bill seeks to achieve.[3]

2.3 The rights of equality before the law and non-discrimination outlined in the UNCRPD require immediate realisation. The UNCRPD Committee has been clear that impairments are not a legitimate ground for the denial or restriction of human rights or for denying legal capacity.[4] Both the UNCRPD and CAT Committees have noted that the MHA needs to

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1 More information about the Law Society's law reform sections and committees is available on the Law Society's website: NZLS | Branches, sections and groups.

2 Ministry of Justice "Consistency with the New Zealand Bill of Rights Act 1990: Mental Health Bill" (12 September 2024).

3 *Hansen v R* [2007] 3 NZLR 1 (SC).

4 CRPD Committee, General Comments No 1 (2014) and No 6 (2018).

be repealed. UN human rights experts have gone further, calling for an end to all coercive mental health measures.[5]

2.4 On a practical level, the Law Society remains concerned about how the changes will be achieved in practice unless significant resources are deployed. One example of this is that the implementation of the availability of access to an advocate and representative (vital in giving effect to the Bill's approach of centering a person's rights, will and preferences, consistent with international human rights obligations) is likely to be resource intensive, and difficult to attain in all areas of the country. Other examples of resourcing concerns are noted throughout this submission.

3 Clause by clause analysis

Part 1: Preliminary provisions

Clause 3: purpose

3.1 The purpose of the Bill is to provide for compulsory mental health assessment and care in a manner that:

(a) promotes the decision-making capacity of tāngata whaiora, including while they are subject to compulsory care; [6]

(b) improves equity in mental health outcomes among New Zealand's population groups by striving to eliminate mental health care disparities, in particular for Māori;

(c) protects the rights of tāngata whaiora; and

(d) protects the safety and well-being of tāngata whaiora and all other New Zealanders.

3.2 The Law Society generally supports these objectives, with one note of caution about the reference in clause 3(d) to the safety of 'all other New Zealanders'. Among users of the legislation and the wider public, this could invite the inference that people experiencing mental distress are dangerous to others, perpetuating the stigma and discrimination associated with people experiencing mental distress. In reality, evidence shows that people with mental illness are much more often the victims of violence rather than the perpetrators.[7] The Law Society acknowledges the challenges of accommodating this nuance in the legislation.

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5 "UN rights experts call on Council of Europe to stop legislation for coercive mental health measures" (28 May 2021).

6 For express references throughout the Bill to the need to encourage a person to develop and exercise capacity and choice; or the need to deliver compulsory care in a manner that is responsive to, and guided by, the person's will and preferences, see for example clauses 6, 10, 16(2), 19, 23(1) and 43(5). Provisions such as these support a person's ability to participate in decision-making about their care; be supported in their decision-making; and have access to adequate support, advocacy and representation.

7 See, generally, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (November 2018); see too Ministry of Health *He Arotake ngā Tūraru | Reviewing risk* (December 2022).

Recommendation

3.3 The Committee may wish to explore with officials the rationale for and merits of including the phrase 'all other New Zealanders' in clause 3(d).

Clause 4: interpretation

"Forensic patient"

3.4 The Law Society is concerned that inconsistency or tension could arise in the overlapping definitions of 'forensic patient' under the Bill and 'special care recipient' in section 6 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and queries whether this is intended.

3.5 As currently drafted, the practical effect of the Bill would be that a person who is detained in a hospital or secure facility under sections 23(2)(b) or 35(2)(b) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (for example) would be concurrently both a 'forensic patient' under the Bill and a 'special care recipient' under section 6(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act. For those who are, potentially, both intellectually disabled and mentally disordered and are subject to both forms of compulsory care, the legislative overlap could be complex.

Recommendation

3.6 The Law Society queries whether the overlap is intended and recommends further consideration of this issue.

Clause 5: Te Tiriti o Waitangi (Treaty of Waitangi)

3.7 Clause 5 lists the provisions contained in the Bill that provide for the Crown's intention to give effect to the principles of the Treaty of Waitangi — such as striving to eliminate mental health care disparities, in particular for Māori, and requiring the membership of a Mental Health Review Tribunal and the Forensic Patient Review Tribunal to include knowledge of tikanga and mātauranga Māori.

3.8 The Law Society supports the inclusion in the Bill of a specific Treaty clause, and the provisions in the Bill that require the Crown to take steps towards giving effect to the Treaty's principles.

3.9 While the provisions identified in clause 5 may be particularly pertinent, the intention to give effect to the Treaty and to its principles should apply to the future Act as a whole, and be embedded at all levels and stages including design of the Bill itself. The findings of the Waitangi Tribunal in its *Hauora* report[8] and the *Whanaketia* report of the Royal Commission of Inquiry into Abuse in Care[9] remain apposite, particularly:

(a) empowering tino rangatiratanga of hauora Māori;[10]

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8 Waitangi Tribunal *Hauora: The Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wai 2575, 2021).

9 Abuse in Care Royal Commission of Inquiry *Whanaketia* (25 June 2024).

10 Wai 2575 at 191 and final recs.

(b) requiring and sufficiently resourcing culturally relevant and appropriate responses to wellbeing and distress.

3.10 While the Law Society has not made further specific recommendations on these matters (and some may be matters for implementation rather than legislation), it is noted that the Bill could go further in addressing them.

Clause 6: compulsory care principles

3.11 Clause 6 sets out the compulsory care principles that apply for the purposes of the legislation. Clause 6(1)(a)(ii) provides that compulsory care should be used only to protect, promote, and improve a person's mental health, and if suitable care to protect, promote, and improve a person's mental health is available. The phrase 'suitable care' is not defined in the Bill. In the Law Society's view, the phrase should be defined, given that it is a principle to be applied by those performing a function or duty or exercising a power in under the Act in respect of a person.

3.12 Clause 6(1)(b)(iii) refers to 'support' available to the person, in the forms of whānau and cultural support. The Law Society suggests that 'support' should be defined and should extend to matters such as housing, counselling, and linking with community organisations and other agencies that are able to support the person.

3.13 Clause 6(1)(c)(ii) provides that compulsory care should reflect the needs of the person including their cultural needs and be responsive to any trauma experienced by them. The primary focus on cultural needs in this clause seems narrowly drafted. The Law Society considers that the clause should be drafted more broadly to encompass other matters such as person's health and well-being needs, including needs such as housing and self-care.

3.14 Clause 6(3)(c)(iii) states that compulsory care should be delivered in a manner that is responsive to and guided by the person's will and preferences. In this clause, the committee may wish to consider amending the phrase 'will and preferences' to include *rights*, will and preferences, in accordance with article 12(4) of the UNCPRD, which New Zealand ratified in 2008.

Recommendations

3.15 The Law Society recommends that:

(a) Clause 6(1)(a)(ii) is amended to define the phrase 'suitable care'.

(b) Clause 6(1)(b)(iii) is amended to define 'support' and include such additional support suggested above.

(c) Clause 6(1)(c)(ii) is amended to extend its scope to encompass the person's health and well-being needs, including needs such as housing and self-care.

(d) Clause 6(3)(c)(iii) is amended to insert the word 'rights' before 'will and preferences'.

Clause 7: compulsory care criteria

3.16 Clause 7 sets out the compulsory care criteria that must be met before a person can be admitted to compulsory care. Clause 7(1) provides that the compulsory care criteria are met if:

(a) the person has seriously impaired mental health; and

(b) the seriously impaired mental health causes, or is likely to cause in the near future, in the absence of care, serious adverse effects; and

(c) the seriously impaired mental health causes the person to *lack capacity* to make decisions about their mental health (emphasis added).

3.17 Clause 7(2) then sets out the meaning of serious adverse effects, being:

(a) serious physical harm to self or others; or

(b) serious psychological harm to others; or

(c) serious deterioration in a person's mental or physical health.

3.18 'Serious adverse side effects' in clause 7(1)(b) will need to be read in the light of the definition of 'serious adverse effects' in clause 7(2). In the Law Society's view, clause 7(2)(b) should be amended to include serious psychological harm to self, in addition to others.

3.19 The third criteria set out at clause 7(1)(c) requires the seriously impaired mental health of the person to have caused them to lack capacity to make decisions about their mental health care. Under the Bill, a person is presumed to have capacity to make decisions about mental health care unless they cannot, on a sustained basis:[11]

(a) understand the mental health care options available to them; or

(b) understand the consequences of making a particular decision to accept or not accept mental health care options; or

(c) retain, use, and weigh relevant information to make decisions about mental health care options; or

(d) communicate decisions about mental health care in any way.

3.20 The addition of the capacity criterion is a major change from the current MHA and is among the most significant changes proposed in the Bill. It means that a person cannot be subject to compulsory care if they have decision-making capacity in relation to their mental health care; and that they must be released from compulsory care as soon as they regain decision-making capacity in relation to their mental health care.[12] This is consistent with the Bill of Rights, and with approaches in other jurisdictions.

3.21 There are, however, some concerns from the Law Society's perspective that the new approach could have unintended consequences. For example, there will be persons who have seriously impaired mental health which causes serious adverse effects but where

11 Clause 9(1).
12 Clauses 53(1), 61, 66, 76(2) and 81.

the person is deemed to have capacity to make decisions and therefore cannot be assisted or treated under compulsory care. This could lead to poor outcomes.

Recommendations

3.22 The Law Society recommends that clause 7(2)(b) is amended to include serious psychological harm *to self* or others.

Clause 8: meaning of seriously impaired mental health

3.23 Clause 8 defines 'seriously impaired mental health'. Clause 8(2) sets out criteria that cannot 'solely' be considered to form part of whether a person has seriously impaired mental health. While the intent behind the section is clear, in the Law Society's view some of these factors should never be taken into account to assess whether a person has seriously impaired mental health. These include political, religious, philosophical, or cultural beliefs, values or opinions; sexual preferences; gender identity; lack of social engagement; and intellectual disability. Clauses 8(2)(a) to (d) and (g) should be deleted.

Recommendation

3.24 The Law Society recommends that clauses 8(2)(a) to (d) and (g) are deleted.

Clause 9: meaning of capacity to make decisions about mental health

3.25 Clause 9 defines the phrase 'capacity to make decisions about mental health care'. A 'person is presumed to have capacity to make decisions about mental health care unless they cannot, on a sustained basis …'. The Law Society supports the use of the term 'sustained basis', but notes a risk that it could be seen to conflict with the phrase 'continuous or intermittent', which is used in both clauses 8(1) and 9 of the Bill. Clause 9(2)(b) states that a person who determines whether a person lacks capacity to make decisions about mental health 'may disregard brief or intermittent indications of capacity'. Further clarity on the interface between 'continuous and intermittent' and 'sustained basis' under clause 9 would be helpful.

Recommendation

3.26 The Law Society recommends that clauses 8 and 9 are reviewed to ensure there is no conflict between the use of 'continuous and intermittent' and 'sustained basis'.

Part 2: Tāngata whaiora rights and support

Clause 14: witnessing compulsory care directive

3.27 Clause 14 allows a person acceptable to the maker of a directive to be a witness. There is no criteria or restriction on who can be a witness other than that they are acceptable to the maker. In the Law Society's view, there should be a definition or criteria to be a witness, including being over the age of 18 years of age, and not being under a current compulsory care order.

3.28 In addition, there is a significant onus placed upon the witness who must confirm pursuant to clause 14(2)(a) and (b) that the person is making or revoking the directive of their own free will and that the maker understands the nature and effect of the directive

or revocation. The Law Society is concerned that a layperson with no criteria or definition may not be able to confirm that the person for whom they are witnessing understands the nature and effect of the directive or revocation. Such a confirmation should be carried out by either a Justice of the Peace, a second medical practitioner, a mental health nurse or other mental health worker, or a lawyer acting for the person.

Recommendations

3.29 The Law Society recommends that clause 14 should be amended to provide:

(a) criteria for who can or cannot be a witness; and

(b) that a defined person(s) other than the witness is confirming that the maker is making or revoking the directive of their own free will and understands the nature and effect of the directive or revocation.

Clause 17: hui whaiora (well-being meetings)

3.30 Clause 17 provides for well-being meetings to be convened to consider matters relating to the care and support of tāngata whaiora (people with lived experience of mental distress) and for other specified purposes. A new clause 17(4)(f) should be added to include the lawyer representing tāngata whaiora (if the person has one).

Recommendation

3.31 The Law Society recommends that clause 17(4) is amended to include a new subsection (f), to provide that a lawyer representing tāngata whaiora may attend a hui whaiora.

Clause 19: nominated person

3.32 Clause 19 sets out the role of a nominated person and how a person may appoint a nominated person. Clause 19(2) states that a 'nominated person':

(a) receives information about the appointing person's mental health; and

(b) represents the appointing person's views in decision making processes.

3.33 The Law Society considers that there should be a definition or criteria to be a nominated person, including being over the age of 18 years of age, and that they are not themselves subject to a compulsory care order. A nominated person will receive private information and have obligations they need to comply with. Ensuring that the nominated person is an appropriate person is particularly important for young people or children with mental health conditions, given their more vulnerable position.

Recommendation

3.34 The Law Society recommends that clause 19 is amended to include minimum criteria for who can be appointed as a nominated person, including being over the age of 18 years, and not being under a current compulsory care order.

Clause 20: witnessing nominated person appointment

3.35 Clause 20 requires the appointment of a nominated person to be witnessed by a person acceptable to the appointing person. This raises the same issue arising under clause 14 and is addressed in those earlier comments.

Recommendation

3.36 The Law Society recommends that clause 20 is amended to provide:

(a) criteria for who can or cannot be a witness; and

(b) that a defined person(s) other than the witness must confirm that the appointing person is making the appointment, and the nominated person is accepting the appointment, of their own free will and that both the appointing person and the nominated person understand the nature and effect of the appointment.

Clause 23: independent support person

3.37 Clause 23(4) provides for the Director-General to issue guidelines under section 204(1)(a) relating to independent support persons. If the role of an independent support person is to remain, the duties related to that role should be explicitly included in the legislation rather than by the issuing of guidelines. However, the Law Society has concerns about the number of different roles proposed in the Bill, as explained further under clause 24.

Recommendation

3.38 The Law Society recommends that clause 23(4) is deleted and the duties related to the role of an independent support person (if this role is retained) are explicitly included in the legislation.

Clause 24: advocate

3.39 Clause 24 sets out the role of and provides for requirements relating to an advocate. The clause also requires Health New Zealand to ensure that a reasonable number of advocates are available to patients. Clause 24(2)(a) to (e) sets out various functions that an advocate can perform, in addition to the functions of an independent support person. Clause 24(4)(b) provides that an advocate cannot act as an independent support person in the same case unless it is not reasonably practicable for those roles to be performed separately. It is unclear what this means, and the clause should be amended to provide clarity.

3.40 The functions of an advocate and an independent support person are similar to a lawyer's role and may conflict with the reserved areas of work defined in section 6 of the Lawyers and Conveyancers Act. This is particularly so in terms of clause 24(2)(c), which provides for an advocate to *represent patients in processes and proceedings provided for under this Act* (emphasis added). In the Law Society's view, clause 24(2)(c) should be deleted or, alternatively, the word 'represent' in clause 24(2)(c) should be deleted and replaced with 'assist'.

3.41 The Law Society is aware of recent concerns raised in respect of lay advocates in the employment law jurisdiction[13] and suggests similar concerns may exist for the establishment of lay advocates in the mental health jurisdiction. Those concerns include the lack of regulation, which means lay advocates are not bound by the same codes of conduct or standards as lawyers.

3.42 There is no reference in the Bill to the independent support person or the advocate being paid but under clauses 23(2) and 24(3) Health New Zealand has a legislative obligation to ensure that independent support persons are available to all patients and that a reasonable number of advocates are available to patients. It is unclear from the Bill where this available pool of people will come from, whether the role is remunerated, and the qualifications and/or experience they are required to have.

3.43 These two roles are independent of the roles of a nominated person, the District Inspector and of the court-appointed lawyer appointed to represent the person. It is unclear how these five roles will interact and work together in a way that will achieve the purpose and principles of the legislation. In addition, there appears to be no machinery in the Bill to address situations where there is disagreement or a conflict of duties that arise between the various roles.

3.44 There will be potentially many occasions where a patient is dealing with an independent support person, an advocate, a nominated person, the district inspector, and their lawyer. The number of people may prove confusing to a patient in a vulnerable state, particularly where they might be given conflicting information on their rights and the processes and proceedings under the legislation. In addition, the appointment of an independent support person and an advocate may be difficult in smaller centres and provincial areas where there is already a lack of staffing and funding of services.

3.45 In the Law Society's view, it is unnecessary for there to be three separate roles (independent support person, advocate, nominated person). If there is to be a role, one role would be preferable — either an independent support person or an advocate.

3.46 If these roles are to remain then the duties of each role should be narrowed and clearly specified in the legislation to ensure the roles do not involve legal representation, legal advice or touch on any of the reserved areas of work for lawyers as set out in the Lawyers and Conveyancers Act 2006. The legislation should also clarify how these roles intersect with the role of the person's lawyer and the District Inspector.

Recommendations

3.47 The Law Society recommends that:

(a) Clause 24(2)(c) should be deleted or, alternatively, the word 'represent' should be replaced with 'assist'.

(b) The Bill is amended to:

13 See the Law Society's letter of 5 December 2023 to the Minister for Workplace Relations and Safety (lawsociety.org.nz/assets/Law-Reform-Submissions/Letter-to-Minister-for-Workplace-Relations-and-safety-2023.pdf), and Michael Andrew "Why Lay Advocates need to be Regulated" (Law Association, *LawNews*, 12 November 2024).

(i) include only one role — either an independent support person or an advocate;

(ii) narrow the duties of each role, if they are to remain, so they are not in breach of the Lawyers and Conveyancers Act 2006, and provide clarity on how the five roles will interact and work together in a way that will achieve the purpose and principles of the legislation; and

(iii) provide machinery to address situations where there is disagreement or a conflict of duties that arise between the various roles.

Clause 28: right to medical and other health care

3.48 Clause 28 provides that a patient is entitled to medical and other health care suitable for their mental and physical health needs, and that a responsible practitioner must take steps to ensure that this is available to the patient. An addition to this clause should be made, requiring the provision of suitable medical and other health care to occur in a timely manner.

Recommendation

3.49 The Law Society recommends amending clause 28(2) by inserting 'in a timely manner' after the words 'available to the patient'.

Clause 30: right to independent health advice

3.50 Clause 30 provides that a patient is entitled to seek a consultation with a mental health practitioner of their choice to get a second opinion, and, if the practitioner agrees to the consultation, they must be permitted access to the patient upon request. It may be desirable to provide that, if necessary, and as a last resort, this can occur by way of telephone or audiovisual link.

Recommendation

3.51 The Law Society recommends clause 30 is amended to allow practitioner-patient consultations to occur by telephone or audiovisual link if necessary, and as a last resort.

Clause 38: rights of children and young persons

3.52 The explanatory note to the Bill says that it ensures 'wherever possible' that children and young people are cared for by child and adolescent mental health services. However, clause 38(1) speaks of 'wherever practicable'. The language of the explanatory note and Bill should align.

Recommendation

3.53 The Law Society recommends rewording to align the language of the explanatory note and clause 38.

Part 3: Compulsory care

Clause 50: electroconvulsive therapy

3.54 Clause 50 limits the use of electroconvulsive therapy, referring to decisions that may be made on the advice of 'an appropriately qualified mental health practitioner' if the patient does not have capacity to make their own health care decisions or is younger than 18. The Bill's definition of 'mental health practitioner' includes a nurse practitioner and a registered nurse practising in mental health (as is the case under the present MHA).[14]

3.55 The Law Society supports this wider definition of 'mental health practitioner' where it is used in other parts of the Bill. However, for decisions about electroconvulsive therapy, the Law Society questions whether it is intended that 'mental health practitioner' is the right term in this context, compared with section 60(b) of the MHA, which requires a psychiatrist to consider that the treatment is in the patient's best interests.

Recommendation

3.56 The Law Society recommends the Committee consider whether use of term 'mental health practitioner' rather than 'psychiatrist' is intended to broaden the range of individuals who can make a decision to use electroconvulsive therapy. As it seems unlikely this was intended, clause 50(1)(b) and (c) should be amended to replace the term 'mental health practitioner' with 'psychiatrist' (or another appropriate term).

Clause 51: restricted treatments

3.57 Clause 51 prohibits the use of a restricted treatment (any treatment intended to destroy any part of the brain or brain function, or any other treatment specified in regulations) except in specific circumstances. The clause is comparable to section 61 (special provision relating to brain surgery) in the MHA.

3.58 Clause 51(1)(c)(ii) contains a requirement that a mental health practitioner who has been appointed for the purpose of this section by the Mental Health Review Tribunal considers the treatment to be in the interests of the patient. However, as discussed above in respect of clause 50, the Bill's definition of 'mental health practitioner' includes a nurse practitioner and a registered nurse practising in mental health.

3.59 By contrast, section 61(c)(ii) in the MHA refers to a psychiatrist. The Law Society recommends consideration by the Committee of whether the change to the significantly broader term 'mental health practitioner' was intended, and whether narrowing clause 51(1)(c)(ii) by replacing the words 'mental health practitioner' with the word 'psychiatrist' may be a safeguard.

Recommendation

3.60 As with clause 50, the Law Society recommends the Committee address whether choice of the broader term 'mental health practitioner' rather than 'psychiatrist' in clause

14 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2 "mental health practitioner".

51(1)(c)(ii) was intended. Again, it seems unlikely this was intended, and clause 51(1)(c)(ii) should therefore be amended to replace the term 'mental health practitioner' with 'psychiatrist' (or another appropriate term).

Clause 53: release from compulsory care

3.61 Clause 53 relates to release from compulsory care. Under clause 53(2), if a district inspector, an official visitor, or a member of the patient's support network disagrees with the decision of the responsible practitioner that there are reasonable grounds to believe that the patient meets compulsory care criteria, they may refer the patient's case to a Mental Health Review Tribunal for consideration.

3.62 In the Law Society's view, in addition to a district inspector, an official visitor, or a member of the patient's support network, clause 53(2) should include the patient themselves, and their lawyer. (As presently drafted, 'support network' as defined in clause 18 does not refer to the patient's lawyer.)

Recommendation

3.63 The Law Society recommends that clause 53(2) is amended as suggested above.

Clause 56: examination and application

3.64 Clause 56 sets out the application process for a first assessment. In other parts of this submission (see clauses 65, 76, 80, 81 and 86), the Law Society has suggested amendments to the 'reasonable grounds to believe' threshold. However, in clause 56 the 'reasonable grounds to believe' threshold is an appropriate one to be used, given it applies to a first assessment.

Clause 60: compulsory care criteria met

3.65 Clause 60 sets out the requirement for a second assessment if the first assessment has found that there are reasonable grounds to believe that the proposed patient meets the compulsory care criteria. Repeating the comments above at clause 56: the Law Society considers that the 'reasonable grounds to believe' threshold is an appropriate one to be used in clause 60, given it applies to a first assessment.

Clause 64: examination of the patient undergoing second assessment by judge

3.66 Clause 64 provides that a patient or a member of the patient's support network may apply at any time during the second assessment period to the Family Court to have a judge examine the patient. Following the prescribed examination, the judge must order that the patient be released from compulsory care immediately if the judge is satisfied that the patient does not meet the compulsory care criteria. Clause 64(1) does not include a lawyer acting for the patient. In some regions, the district inspector or the hospital will arrange for a lawyer from the approved list of mental health lawyers to meet with the patient and then file an application. Clause 64(1) should be amended to include a lawyer acting for the patient.

Recommendation

3.67 The Law Society recommends that clause 64(1) is amended to enable a lawyer acting for the patient to apply to the court to have a judge examine the patient.

Clause 65: record of second assessment

3.68 Clause 65 provides that the responsible practitioner must record the outcome of the second assessment before the expiry of the second assessment period and specifies the people to whom the record must be provided. The Law Society proposes four minor amendments to the clause.

3.69 Clause 65(1)(a)(ii) requires that before the expiry of the second assessment period, the responsible practitioner must record whether they consider that there are (or are not) reasonable grounds to believe that the patient meets the compulsory care criteria. For the reasons discussed below (clause 76), the Law Society has concerns that 'reasonable grounds to believe' is not the right threshold in this context. The words 'there are reasonable grounds to believe' should be deleted from clause 65(1)(a)(ii).

3.70 Clause 65(2)(a) to (g) does not include a lawyer acting for the patient. Clause 65(2) should be amended to add a new subclause (h) to include a lawyer acting for the patient.

3.71 Clause 65(3) provides that the district inspector who receives a copy of the record of the second assessment must communicate with the patient and find out, if possible, whether the patient wants the district inspector to appear before the court to be heard[15] and decide, having regard to any view expressed by the patient, whether the district inspector should appear before the court to be heard.[16]

3.72 Providing for the district inspector rather than the lawyer for the patient to appear before the court to be heard on the application for a mental health care order may be impractical given the number of district inspectors and patients. The Law Society suggests that clause 65(3)(a) could be amended as follows:

> … communicate with the patient and find out, if possible, whether the patient wants to be represented by a lawyer and assist them in having a lawyer appointed to represent them on the application for a mental health care order.

3.73 If this proposal is accepted, clause 65(3)(b) can be deleted.

Recommendations

3.74 The Law Society recommends that:

(a) Clause 65(1)(a)(ii) is amended by deleting the words 'there are reasonable grounds to believe'.

(b) Clause 65(2) is amended to add a new subclause (h) to include a lawyer acting for the patient.

(c) Clause 65(3)(a) is amended as suggested above.

15 Clause 65(3)(a).
16 Clause 65(3)(b).

(d) If clause 65(3)(a) is amended as suggested, clause 65(3)(b) is deleted.

Clause 68: status of patient pending determination of application

3.75 Clause 68 deals with the status of the patient pending determination of the application for a mental health care order. The maximum time period for a second assessment is 19 days starting on the day on which the patient is notified.[17] The second assessment has a timeframe of 19 days, then there is a further 14 days after the second assessment period ends within which the judge must see the patient.[18] If, after examining the patient, the judge considers that it is not practicable to determine the application within the 14-day period, the judge may, by interim order, extend that period for a further period not exceeding one month.[19] If the matter cannot be determined within that timeframe, the application must be dismissed, and the patient must be released from compulsory care.[20]

3.76 The Law Society suggests amending clause 68(1) to clarify that the length of the second assessment period is 19 days as follows:

> If the responsible practitioner applies to the court for a mental health care order, the patient who is subject to the second assessment period of 19 days, in accordance with the terms of the notice given under section 60, remains under the assessment process for a further 14 days after the second assessment period ends.

Recommendation

3.77 The Law Society recommends that clause 68(1) is amended to clarify that the length of the second assessment period is 19 days.

Clause 70: jurisdiction of Family Court

3.78 Clause 70 provides that the Family Court has jurisdiction to hear and determine an application under this Bill unless it is not practicable to have the application determined within a required period, in which case a District Court judge may hear and determine it. This clause also provides that if a judge is required to conduct an examination, the judge must be a Family Court judge. If it is not practicable for a Family Court judge to examine a patient, the examination may be conducted by a District Court judge. However, clause 70(3) (which provides that only a Family Court judge can conduct an examination under this Act) is not subject to clause 70(4) (which allows a District Court judge to undertake the examination if it is not practicable for a Family Court judge to do so). This could be clarified by adding the phrase 'unless otherwise provided' to the end of clause 70(3).

Recommendation

3.79 The Law Society recommends that clause 70(3) is amended by adding the words 'unless otherwise provided' after 'Family Court judge'.

17 Clause 62(2).
18 Clause 68(1).
19 Clause 68(2).
20 Clause 68(3)(a) and (b).

Clause 73: judge to examine patient

3.80 Clause 73 sets out the requirements relating to an examination of a patient by a judge. If the judge is satisfied that the patient does not meet the compulsory care criteria, the judge must order that the patient be released from compulsory care immediately. Clause 73(1) provides that 'a Judge must examine the patient as soon as practicable and no later than 14 days after the application is filed in the court'. This mirrors section 18(1) of the MHA in terms of timeframes.

3.81 In practice, if the patient fails to attend and cannot be brought before the court within the 14-day timeframe, the application for a care order ('compulsory treatment order' in the MHA) will lapse. The Bill does nothing to cure this. In the Law Society's view, amending the Bill is an opportunity to ensure the failure of the patient to attend court does not result in the application immediately lapsing. The Law Society suggests that a new subsection be added that provides:

> If the patient fails to attend an examination scheduled pursuant to s 14(1), the examination may be rescheduled on one occasion and shall take place no later than 14 days after the date of the failed examination date.

3.82 Clause 73(4)(b) provides that a judge must make reasonable efforts to consult the patient's nominated person (if any), principal caregiver, and whānau. There is no guidance as to how this is to be achieved, and it does not reflect the reality of the judicial process. If those persons are present or have provided information via mental health professionals or in some other form, then that information should be taken into account. Beyond that, a judge's ability to make inquiries is limited. The Law Society suggests that clause 73(4)(b) is amended to provide that the judge 'must take into account any views made available to the court either directly or indirectly from the patient's nominated person (if any), principal caregiver, and whānau wherever practicable'.

Recommendations

3.83 The Law Society recommends:

(a) the addition of a new subsection to clause 73 to the effect suggested above, to ensure the failure of the patient to attend court does not result in the application lapsing; and

(b) that clause 73(4)(b) is amended to provide that the judge 'must take into account any views made available to the court either directly or indirectly from the patient's nominated person (if any), principal caregiver, and whānau wherever practicable'.

Clause 75: court may dispense with hearing in certain circumstances

3.84 Clause 75 provides that a court may determine a mental health care order application without a formal hearing (but after an examination) if it is satisfied that no person wishes to be heard in respect of the application. Although a patient will usually have legal representation prior to the clause 73 examination, that will not always be the case.

3.85 A patient declining to be heard results in the application proceeding unopposed. It is imperative that a patient knows the likely ramifications of such an approach. Patients

subject to a care order application are by their nature vulnerable. They may feel pressured not to a require a hearing or elect this option as being 'easier' without having a proper understanding of the impact of a care order or their prospects of success at hearing. In the Law Society's view, clause 75 should be amended to ensure that it is subject to equivalent protection for the patient as the requirement to have had legal advice that is in clause 100(2) of the Bill. Accordingly:

> The waiver by the patient of the right to be heard must be—
>
> (a) given on the advice of a lawyer; and
>
> (b) provided in writing to the court and the Director of Area Mental Health Services or communicated at the conclusion of the s 73 examination by the patient's lawyer to the Judge.

Recommendation

3.86 The Law Society recommends that clause 75 is amended as suggested above.

Clause 76: court to determine if compulsory care criteria met

3.87 Clause 76 provides that the court must determine, on a mental health care order application, whether there are reasonable grounds to believe that the patient meets the compulsory care criteria. If the court considers that the patient does not meet the criteria, it must order that the patient be immediately released from compulsory care. If the court considers that the patient does meet the criteria, it must determine, having regard to all the circumstances of the case, whether it is reasonably necessary to make a mental health care order.

3.88 Clause 76(1) as currently drafted uses the phrase 'whether there are reasonable grounds to believe'. This imposes a standard of proof lower than the usual civil standard. Presently under the MHA, the civil standard of 'on the balance of probabilities' applies. The lower standard of proof 'whether there are reasonable grounds to believe' is usually only seen in preliminary applications such as a defence to a summary judgment application or leave to appeal where the court is yet to determine if the grounds exist or not. Reasonable grounds to believe is less than a determination that the grounds are made out.

3.89 A lower standard of proof is inappropriate in these cases, particularly having regard to the approach of the least intervention and the impact of a care order on a person's rights. For an order to be made, the court should be satisfied that the patient does meet the compulsory care criteria, not just that there are grounds to believe they might. There is no justification for a lesser standard. Clause 76(1) should be amended to provide that 'the court must determine that the patient meets the compulsory care criteria'.

Recommendation

3.90 The Law Society recommends that clause 76(1) is amended to provide that the court must determine that the patient meets the compulsory care criteria.

Clause 78: community care orders

3.91 Clause 78 sets out the required content of a community care order, including a requirement to specify both the place for receipt for the care and which service provider shall provide it. However, there does not appear to be any ability under clause 78 to amend either the place or service provider named in the order during the term of the order, other than pursuant to clause 82.

3.92 As clause 82 presently only relates to the power to direct an inpatient admission, the Law Society has suggested as a recommendation under that clause that it is amended to allow for a variation to the location and provider of care in circumstances where the patient consents.

3.93 Under clause 78(2), an employee of the service specified in the order who is authorised to provide care to the patient may enter the patient's place of residence or other specified place when reasonably necessary to provide care to the patient. Given the invasiveness of such a power, the Law Society recommends limiting the ability to do this to when the person consents to it, or to emergency situations. Doing so would be consistent with the focus of the Bill on the person's rights, will and preferences.

Recommendation

3.94 The Law Society recommends that clause 78(2) is amended, to restrict its application by requiring consent, or to emergency situations.

Clause 79: inpatient care orders

3.95 Clause 79 sets out the required content of an inpatient care order. It includes a requirement to specify the hospital where the patient will receive the care. There does not appear to be any ability to amend the place of admission during the term of the order. Clause 83 provides the power to discharge the patient and for the order to be treated as a community care order. We have suggested as a recommendation under clause 83 that clause 83 is amended to allow for a variation to the place of admission.

Clause 80: care plan and status reviews of persons subject to mental health care orders

3.96 Clause 80 sets out the requirements for the responsible practitioner to conduct care plan and status reviews, the content of the reviews, and the content of the record that must be made of the reviews. The provision also requires the record of status review to be sent to the Director of Area Mental Health Services.

3.97 The 'reasonable grounds to believe' criteria are also present in clause 80(8)(b). At this stage of the process, a care order is in place and a determination has been made by the court. The preliminary assessment period is over, and the order should only continue if the criteria continue to be met (as opposed to there being reasonable grounds to believe they may be met). The period after the making of an order is distinguished from the period pre-determination during which the reasonable grounds to believe standard is appropriate as the evidence has yet to be tested.

3.98 There is an appropriate difference between this clause and clause 76, in that the responsible practitioner is not determining the matter in the same way as a court or tribunal does. Such a differential is maintained using the words 'in their opinion'. Therefore, the reasonable grounds criteria are not required to differentiate between the role of a responsible practitioner and a court.

3.99 For the same reasons set out for clause 76, it is appropriate that the responsible practitioner's opinion is that the patient does meet the compulsory care criteria, and not just that there are grounds to believe the patient might. Clause 80(8)(b) should be amended by removing the words 'there are reasonable grounds to believe that'.

Recommendation

3.100 The Law Society recommends that clause 80(8)(b) is amended by removing the words 'there are reasonable grounds to believe that'.

Clause 81: outcome of status review

3.101 Clause 81 deals with the outcome of a status review. If the responsible practitioner considers that the patient does not meet the compulsory care criteria, the patient must be immediately released from compulsory care and the mental health care order is revoked. If the responsible practitioner considers that there are reasonable grounds to believe that the patient meets the compulsory care criteria, the responsible practitioner is required to forward the record of the review to the patient, a district inspector, and other specified persons. The provision sets out the obligations on the district inspector in respect of assisting the patient to review the outcome of the status review. For the reasons set out under clauses 76 and 80, clause 81(3) should be amended to remove the words 'there are reasonable grounds to believe that'.

Recommendation

3.102 The Law Society recommends that clause 81(3) is amended to remove the words 'there are reasonable grounds to believe that'.

Clause 82: changes to community care orders

3.103 Clause 82 provides that the responsible practitioner may make directions in respect of a community care order if the responsible practitioner considers that the patient cannot be treated adequately as an outpatient. Under clause 82(1) a direction may require the patient to be treated as an inpatient for up to 14 days[21] or to be subject to further assessment.[22] The responsible practitioner may use subsection (1)(a) directions in respect of a patient no more than twice in any 6-month period. The direction must be notified to the patient and other specified persons and must include the reasons for giving the direction. If a direction has been given, the patient may apply to the court to have their condition reviewed.

21 Clause 82(1)(a).
22 Clause 82(1)(b).

3.104 As earlier discussed under clause 78, an amendment is suggested to clause 82 to allow for a variation to the location and provider of care in circumstances where the patient consents. A new subclause 82(4) could be added that provides:

> If, at any time while a community care order is in force, the responsible practitioner considers that the patient can be more effectively treated at a place other than the place specified in the order or by a different service provider than is specified in the order, following consultation with the patient, the responsible practitioner may direct that the patient receive:
>
> (a) treatment at a place other than the place specified in the order; or
>
> (b) care from a service other than the service specified in the order.

3.105 Current clause 82(4) would then become 82(5) and should be amended to open: 'As soon as practicable after giving a direction under subsection (1) or (4) …'

Recommendations

3.106 The Law Society suggests that:

(a) a new clause 82(4) is added as suggested above to allow for a variation to the location and provider of care following consultation with the patient; and

(b) current clause 82(4) becomes clause 82(5) and is amended as suggested above.

Clause 83: changes to inpatient care orders

3.107 Clause 83 provides that the responsible practitioner may direct that a patient be discharged from hospital if the responsible practitioner considers that the patient can be treated adequately as an outpatient. Following that direction, the inpatient care order is treated as a community care order. As discussed under clause 79, the Law Society suggests that clause 82 is amended to allow for a variation to the hospital specified in the order. This could be achieved by the addition of a new clause 83(3) that provides that:

> If, at any time while an inpatient care order is in force, the responsible practitioner considers that the patient can be more effectively treated at a hospital other than the hospital specified in the order, and the patient has been consulted, the responsible practitioner may direct that the patient receive treatment at a hospital other than the hospital specified in the order.

Recommendation

3.108 The Law Society recommends that a new clause 83(3) is added as suggested above.

Clause 86: second and subsequent extensions

3.109 Clause 86 requires the responsible practitioner to arrange for a care plan review and a status review within 14 days before the expiry of a mental health care order extended under clause 85 or a previous extension under this clause. If, following that review, the responsible practitioner is satisfied that there are reasonable grounds to believe that the patient meets the compulsory care criteria, the practitioner may apply to the court to extend the order for a further period of 12 months commencing on the day after the date on which the order would otherwise have expired.[23]

[23] Clause 86(2).

3.110 Clause 86(2) also imports the 'reasonable grounds to believe' standard, which (given an order is in place and a determination has been made by the court) should not be the standard applied. The period after the making of an order is distinguished from the pre-determination period during which the reasonable grounds to believe standard is appropriate. In the Law Society's view, clause 86(2) should be amended by deleting the words 'satisfied that there are reasonable grounds to believe' and replacing them with 'of the opinion that'. This amendment would retain the distinction between the roles of the responsible practitioner as the applicant to the court and the court as the decision-maker, but recognises that the pre-determination assessment period is over.

Recommendation

3.111 The Law Society recommends that clause 86(2) is amended by deleting the words 'satisfied that there are reasonable grounds to believe' and replacing them with 'of the opinion that'.

Clause 88: mental health order ceases to have effect or is changed in certain cases

3.112 Clause 88(2)(b) provides that a mental health care order in respect of any person ceases to have effect if that person is sentenced to imprisonment. While the person will be detained, the Law Society queries the rationale for considering that an extant mental health care order should not continue to apply. This could ensure, for example, that the person may continue to receive treatment in custody to prevent a deterioration of their mental health at a stressful time, which can (in turn) affect their ability to engage with their lawyer and the criminal justice process, and the consequent outcome of their criminal proceedings. Appropriate modifications for a period in custody may need to be allowed (given it is not a community setting). However, a mental health care order should continue to have effect if a patient is imprisoned.

Recommendation

3.113 The Law Society recommends removing clause 88(2)(b).

Clause 89: leave for inpatients

3.114 Under clause 89 of the Bill, leave of absence may be granted to a patient, other than a forensic patient, who is in a hospital in accordance with an inpatient care order. The responsible practitioner may grant the patient a leave of absence from the hospital for a period not exceeding 3 months, and extend the period for a further 3 months.[24]

3.115 If someone is deemed able to have two consecutive periods of 3 months leave, then it is hard to understand how they would meet the inpatient criteria. The Law Society queries whether leave granted beyond a certain (and substantially shorter) period — perhaps at the point of considering an extension of the period — should trigger review of the inpatient care order.

3.116 It would also be appropriate, and consistent with the ethos of the Bill, to require in this clause that leave should be given to the maximum extent clinically appropriate, including during a period of assessment, and is not able to be restricted by resourcing issues. It is

[24] Clause 89(2) and (3).

extremely concerning to find that people who are well enough to go out into the community are nevertheless not able to due to staffing issues. This is an arbitrary and unjustified restriction on their liberty. In practice, this will mean the services will need to ensure adequate staffing. However, staffing issues should not be a reason to justify limitation of a person's rights, including their freedom of movement.

Recommendations

3.117 The Law Society recommends clause 89 is amended to:

(a) require leave to be given to the maximum extent clinically appropriate, including during a period of assessment;

(b) require that leave granted beyond a specified period trigger a review of the inpatient care order; and

(c) provide that resourcing issues are not a reason to justify leave limitations.

Clause 90: absence without leave

3.118 Clause 90(1) provides that a patient who is absent without leave 'may be returned to hospital by any person' during a 3-month period. The Law Society is concerned that this could imply that any member of the public is able to return the person, and recommends that the intentions of this clause are clarified and more guidance is set in place.

Recommendation

3.119 The Law Society recommends further consideration of clause 90(1) to clarify who may exercise the powers to return a person, and provide appropriate guidance and/or limitations (for example, requiring the use of force, if any, to be reasonable).

Clause 92: attendance of patient and other persons

3.120 Clause 92 requires a patient to be present during a hearing, subject to specified patient-focused exceptions. This clause simplifies section 19 of the MHA. It replaces previous grounds for excusing attendance with the ground in clause 92(1)(a) that attendance 'would have a detrimental effect on the patient's health'.

3.121 The Bill does not define or give guidelines as to what would be a 'detrimental effect on the patient's health'. The phrase is also included at clauses 34, 35 and 46 of the Bill. It is a new legal test, which also differs from the phrase 'detrimental to the interests of the patient and to his or her treatment' that occurs in sections 72, 123, 124 and 125 of the MHA. In comparison, the term 'serious adverse effects' is defined at clause 7. In the Law Society's view, clause 92 should give guidance on factors that a judge may consider when assessing the 'detrimental effect on the patient's health'.

Recommendation

3.122 The Law Society recommends that clause 92 is amended to set out factors that a judge may consider when assessing the 'detrimental effect on the patient's health'.

Clause 95: right of notified persons to be heard and call evidence

3.123 Clause 95 sets out the rights of a person notified of the hearing to be heard, call witnesses, and to cross-examine witnesses called by other parties. The clause simplifies section 20 of the MHA, but also re-defines the list of those who may call witnesses and cross-examine to include those notified under clause 71. Clause 71(b) includes reference to the broader new 'support network' (defined at clause 18). The Law Society supports this.

3.124 However, the clause removes the specific provision within section 20(2) of the MHA providing that, when a patient is present and appears capable of addressing the court, the court shall give the patient the opportunity to do so and the court may require persons to withdraw from the court while the patient is addressing the court. In the Law Society's view, the removal of this provision is inconsistent with the objectives and the compulsory care principles of the Bill, in particular clause 6(1)(c)(i) and (iii). Although clause 95 provides that a patient is entitled (as a person notified under clause 71) to be heard by the court, the Law Society considers that clause 95 should be amended to retain specific focus on the patient's right to address the court, by providing that:

> where the patient is present and appears capable of addressing the court, the court shall give the patient the opportunity to do so; and, in any such case, the court may require any person to withdraw from the court while the patient is addressing the court.

3.125 This proposed amendment is consistent with clauses 92(4) and 97, which provide broad powers for the judge to control those present at the hearing.

Recommendation

3.126 The Law Society recommends that clause 95 is amended as set out above.

Part 4: Forensic patients and restricted patients

Clause 105: Application for assessment may be made in respect of persons detained in prisons

3.127 Clause 105 provides for the superintendent of an institution or a clinical psychologist employed by the Department of Corrections to make applications for an assessment if they believe that a person detained in the institution may meet the compulsory care criteria. However, under clause 105(5)(g), the court must not make a community care order in respect of the person.

3.128 The Law Society considers that there should be provision for a community order to be made for someone in custody so that they can easily apply for bail and have the order already in place when bailed or released from custody.

Recommendation

3.129 The Law Society recommends amending clause 105 by deleting subclause (5)(g) and providing instead that the court may make a community care order in the circumstances discussed above, subject to any appropriate interim modifications or caveats.

Clause 107: care plan and status reviews of certain forensic patients

3.130 Clause 107 sets out the requirements for care plan and status reviews of the condition of a forensic patient detained in a hospital under an order of a court made pursuant to section 24(2)(a) of the Criminal Procedure (Mentally Impaired Persons) Act 2003. While the Law Society agrees that a care plan review of the patient should take place at monthly intervals and a status review at 3-monthly intervals, it is doubtful whether that is realistic in terms of staff resourcing.

Clause 120: Forensic Patient Review Tribunal may cancel leave of forensic patient

3.131 Clause 120 provides that the Forensic Patient Review Tribunal may cancel a leave of absence and provides for the admission or re-admission of the forensic patient to a hospital. While the Law Society agrees that the Tribunal may cancel a patient's leave, the Tribunal should give reasons as to why the leave was cancelled.

Recommendation

3.132 The Law Society recommends amending clause 120 to provide that if the Tribunal cancels a leave of absence of a patient, it must give reasons for its decision.

Clause 128: Director may cancel short-term leave of forensic patients

3.133 Clause 128 provides that the Director of Mental Health may cancel a leave of absence and provides for the admission and re-admission of the forensic patient to a hospital. The Law Society agrees that the Director should have the ability to cancel short-term leave, but considers that they should be required to give reasons for that decision.

Recommendation

3.134 The Law Society recommends amending clause 128 to require the Director to provide reasons for the decision to cancel a patient's leave.

Clause 132: patients presenting special difficulties may be drawn to Director's attention

3.135 Clause 132 sets out the process for application to the court for an order under clause 133 that a patient subject to an inpatient care order be declared a restricted patient. Clause 132(4) defines 'presents special difficulties' to mean that 'the patient poses an unacceptable risk of seriously endangering the physical or psychological safety of another person'. In the Law Society's view, the definition should also include the patient's risk of self-harm. In addition, an inpatient may not present a danger to the community but could still harm doctors, hospital staff or other patients. While this will be captured by the definition, the phrase could be better defined.

Recommendation

3.136 The Law Society recommends that clause 132(4) is redrafted to clarify the definition and to also include the patient's risk of self-harm.

Part 5: Reviews, appeals and judicial enquiries

Clauses 138 and 142: Forensic Patient Review Tribunal reviews and appeal against Mental Health Review Tribunal's decision in certain cases

3.137 Appeal gaps under the present law have faced criticism, including international criticism from human rights bodies of the robustness and independence of the Tribunal process and its powers. It was hoped the new Bill would correct these, to give patients greater substantive appeal rights than judicial review. The present system of judicial inquiries is problematic for a number of reasons, including its lack of accessibility — requiring, for example, access to lawyers — and, in some respects, its inflexibility.

3.138 As drafted, this remains an issue in the legislation. The Law Society has concerns regarding two significant issues affecting forensic and restricted patients (including children and young persons who become a forensic or restricted patient):

(a) the absence of involvement of the court in reviews of forensic patient status (former special patients); and

(b) the lack of meaningful appeal avenues for restricted patients.

The absence of court involvement in reviews of forensic patient status (former special patients): clause 138

3.139 Under the MHA, the system of Executive involvement to release a person from forensic patient status has allowed the Forensic Patient Review Tribunal only recommendatory power. A forensic patient can only seek judicial review of the outcome of an adverse decision. There are no appeals from the Tribunal decision or from a decision by the Attorney-General or Minister. This has recently been the subject of comment in the High Court on a review concerning the legality of the Minister's powers to decline to release someone from special patient status in the face of a positive recommendation from the Tribunal.[25]

3.140 Clause 138 of the Bill proposes some welcome improvements:

(a) Under clause 138(9), for forensic patients detained following their acquittal by reason of insanity the Tribunal must record its findings and make a direction, meaning that its power is no longer only recommendatory.

(b) In the case of a forensic patient who was ordered to be detained following a finding of unfitness to stand trial, the Tribunal's powers remain recommendatory. Clause 138(8)(c) provides that the Attorney-General, not the Minister of Health, is the law officer responsible for making the final decision, and the Law Society considers that this change is appropriate.

3.141 However, there remains no appeal right from an adverse Tribunal decision for a forensic patient. The Law Society recommends that appeals should be provided for.

The lack of meaningful appeal avenues for restricted patients: clause 142

25 *AW v Minister of Health* [2024] NZHC 2279. Whether this is Bill of Rights-inconsistent is yet to be dealt with in a separate hearing in this proceeding and will be an important case.

3.142 The scheme of the Act has to date denied appeal rights from the Tribunal for restricted patients, until a person in this position becomes a patient under a 'regular' compulsory treatment order.[26] This may take a long time, or never eventuate. Clause 142 of the Bill retains this approach, and the substantive appeal and review rights of restricted patients are not materially altered.

3.143 The Law Society suggests that oversight by the higher courts in such cases is important to monitor the long-term ongoing detention of persons detained outside the criminal justice system. As above, it would be desirable to consider what steps may be taken in the Bill to enable an appeal right for restricted patients.

Recommendation

3.144 The Law Society recommends that the Bill is amended to provide that a forensic patient or a restricted patient has a right of appeal from decisions under clauses 138 and 142.

Clause 140: application to revoke appointment of nominated person

3.145 Clause 140 provides for a Mental Health Review Tribunal to revoke the appointment of a patient's nominated person in specified circumstances. As earlier noted under clause 24, the Law Society has concerns about the various roles of an advocate, a nominated person, and independent support person and considers that it is unnecessary for there to be three separate roles. If there is to be a role, one role would be desirable — either an independent support person or an advocate. If that is accepted, clause 140 can be deleted. Alternatively, clause 140 should remain if the role of nominated person is retained.

Recommendation

3.146 The Law Society recommends that:

(a) Clause 140 is deleted if the recommendation for one role is accepted, of either an independent support person or advocate.

(b) Alternatively, clause 140 should remain if the role of nominated person is retained.

Part 6 Administration and public assistance

Clause 164: appointment of Mental Health Review Tribunals

3.147 Clause 164 empowers the Minister for Mental Health to appoint Mental Health Review Tribunals and specifies requirements for Tribunal membership. The Law Society agrees that the Ministerial power is appropriate but recommends some clarification and modification of this clause in respect of the requirement for the Minister to be satisfied that the Tribunal's membership has lived experience of being subject to compulsory mental health care.

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[26] The High Court in *A v CCDHB* [2022] NZHC 1702 at [40] found that section 83 of the MHA does permit a right of appeal for a patient whose review occurs under sections 80 or 81, but only in respect of their compulsory status and not their special or restricted patient status.

3.148 Matters relating to this requirement which it would be desirable to clarify include that:

(a) It is not clear how long qualifies a person as having appropriate 'lived experience'.

(b) It is also not clear what is meant at clause 164(4) that 'the Minister must be satisfied that the membership of the Tribunal has lived experience'. The intention, presumably, is that the membership, collectively, includes one or some members with lived experience.

3.149 Clause 164(4)(a) should be amended to modify the requirement of the Minister to be satisfied that the membership of the Tribunal has lived experience of being subject to compulsory mental health care to where this is reasonably practicable.

Recommendation

3.150 The Law Society recommends amending clause 164 to clarify the above drafting matters and provide that lived experience of being subject to compulsory mental health care is a requirement 'where reasonably practicable'.

Clause 167: meetings and powers

3.151 Clause 167 sets out requirements for holding meetings of Mental Health Review Tribunals and provides that Tribunals have the same powers and authority to summon witnesses and receive evidence as an inquiry under the Inquiries Act 2013 (other than under section 28). While the Law Society has no issue with clause 167(2) and agrees that at times the use of audiovisual link is necessary, the clause should be amended to make it clear that in-person attendance at meetings should be the default position rather than the use of audiovisual link.

Recommendation

3.152 The Law Society recommends amending clause 167(2) to clarify that an in-person attendance at meetings is the default approach.

Clause 171: review principles

3.153 Clause 171 sets out the principles to guide a Mental Health Review Tribunal when reviewing applications and complaints. Adding the words 'where appropriate' after the words 'having particular regard to tikanga Māori' may help to clarify this provision's (presumed) intent.

Recommendation

3.154 Clause 171(b) should be amended to add the words 'where appropriate' after the words 'tikanga Māori'.

Clause 174: Forensic Patient Review Tribunal

3.155 Clause 174 establishes the Forensic Patient Review Tribunal and sets out requirements for its membership. The Law Society supports the establishment of the Tribunal but, as above in relation to clause 164, questions the practicality of requiring that the membership of the Tribunal must have lived experience of being subject to compulsory

mental health care, and the ambiguity which arises in requiring that the Minister must be satisfied 'that the membership … has lived experience'.[27]

Recommendation

3.156 The Law Society recommends amending clause 174(3)(a) to mirror changes made in clause 164, including providing that lived experience of being subject to compulsory mental health care is a requirement 'where reasonably practicable'.

Part 7: Powers and offences

Clauses 182 and 186: Police powers

3.157 Clause 182 deals with Police powers in relation to persons appearing to meet compulsory care criteria in a public place. Clause 186 also deals with powers of Police when urgent assistance is required. The Law Society comments here particularly in regard to concerns affecting young offenders.

3.158 Police will, potentially, be dealing with mentally unwell young offenders in public. There are also duties and obligations incumbent upon Police when dealing with young people generally (for example, explaining what is happening to young defendants in language they can understand, and consulting with the young person's support network). In the Law Society's view, the legislation should make clear that authorities exercising powers in these types of scenarios are (where applicable) required to implement best practice as it relates to children and young people, whose age compounded by mental health problems makes them particularly vulnerable.

Recommendation

3.159 The Law Society recommends that clauses 182 and 186 require Police exercising powers in respect of children and young people to do so consistent with best practice.

Clause 189: judge or registrar may issue warrants

3.160 Clause 189 sets out the requirements for the issue of a warrant to take a proposed patient or patient to a specified place or to enter premises under clause 181(2). In the Law Society's view, clause 189(4) should be amended to include a District Court judge. That would mean that only if no Family Court or District Court judge is available, then a registrar may issue a warrant.

Recommendation

3.161 The Law Society recommends amending clause 189(4) to also provide for a District Court judge to issue a warrant.

Clause 191: assisting patient on community care order not to attend for care

3.162 Clause 191 creates an offence relating to permitting or assisting a patient not to attend a place they are required to attend for care. In the Law Society's view, the word 'conspire' in clause 191(2)(b) should be replaced by the phrase 'intentionally assist'.

27 Clause 174(3).

Recommendation

3.163 The Law Society recommends amending clause 191(2)(b) to replace the word 'conspire' with the phrase 'intentionally assist'.

Clause 192: assisting patient on inpatient care order to be absent without leave

3.164 Clause 192 creates an offence of permitting or assisting a patient to be absent without leave. In the Law Society's view, the word 'conspire' in clause 192(2)(b) should be replaced by the phrase 'intentionally assist'.

Recommendation

3.165 The Law Society recommends amending clause 192(2)(b) to replace the word 'conspire' with the phrase 'intentionally assist'.

Part 8: Secondary legislation and miscellaneous provisions

Clause 208: giving or sending documents

3.166 Clause 208 sets out the requirements for giving and sending information. As currently drafted, the wording of clause 208(5) is inconsistent with clause 208(6). In saying this, it should be noted that this is also the case under the existing section 133.

3.167 Clause 208(5) and (6) should be amended to be consistent.

Recommendation

3.168 The Law Society recommends that clause 208(5) and (6) are amended for consistency.

Clause 211: annual report on implementation of Act

3.169 Clause 211 requires the Director to publish an annual report on the implementation of the Act. The Law Society notes that the effectiveness of the report will depend on what information is required to be included pursuant to regulations which are not yet available. Without that regulatory detail the Law Society cannot provide fuller comment.

Clause 215: use of audiovisual links

3.170 In line with the current section 6 of the Act, clause 215 relates to the use of audiovisual links by a person other than a judge or a member of a Mental Health Review or the Forensic Patient Review Tribunal. Under clause 215(2), the criteria limit the use of audiovisual links to situations where Person A (the clinician or mental health practitioner) considers it is not reasonably practicable for person B (the patient) to be present and the use of an audiovisual link is appropriate in the circumstances.

3.171 These criteria will continue to result in the use of audiovisual links being the exception rather than the rule, which is appropriate given the vulnerability of patients involved in these processes. The Law Society suggests that clause 215 is amended to make it clear that an in-person appearance is the default position.

3.172 Clause 215(2) should be amended by deleting the words 'Person A considers' as those words insert an unnecessarily subjective element to the criteria. In addition, clause

215(2) should be further amended to include obtaining the person's views (if they are able to be obtained) on the use of an audiovisual link. Clause 215(3) requires Person A to apply any relevant guidelines and standards issued by the Director-General under section 204 in deciding whether the criteria for audiovisual use are met. Those guidelines and standards will influence how the criteria are interpreted in practice. As the guidelines and standards are not yet available, the Law Society cannot provide fuller comment.

Recommendations

3.173 The Law Society recommends that:

(a) Clause 215 is amended to make it clear that an in-person appearance is the default position rather than the use of audiovisual link.

(b) Clause 215(2) is amended by deleting the words 'Person A considers…' and adding the requirement to obtain the person's views (if they are able to be obtained) on the use of audiovisual link.

Clause 216: examination by audiovisual link by judge or member of Tribunal

3.174 Clause 216 provides for the use of audiovisual links for the examination of a person by a judge, a person directed by a judge or a member of a Mental Health Review or Forensic Patient Review Tribunal where they 'consider it is not practicable for the person to be physically present for the examination'. This is in line with the existing provision under section 6A of the Act.

3.175 The Law Society notes that this provision is inconsistent with the more stringent criteria that currently apply to the use of an audiovisual link for an application for extension of a community treatment order under section 34C of the Act. Section 34C(2) and (3) requires the consent of the patient, and under section 34C(4) the judge is required to consider the impact of the use of technology on 'the effective maintenance of the rights of the person', including the right to assess the credibility of witnesses and the reliability of evidence, and 'any other relevant matters'. In the Law Society's view, it is important that the criteria for the use of an audiovisual link are not limited to the practicability of the person being physically present. They should include whether such use is appropriate in all the circumstances, including (where possible) obtaining the views of the patient. Clause 216 should be amended to reflect the wording of section 34C(2) and (3) of the MHA.

Recommendation

3.176 The Law Society recommends amending clause 216 to reflect the wording of section 34C(2) and (3) of the MHA.

Clause 217: transfer of patients

3.177 Clause 217 provides for the transfer of patients. Clause 217 is effectively the same as section 127 under the MHA. However, clause 217(2) and (5) are confusing and it would be desirable to consolidate them as one subsection to provide clarity. The requirement in clause 217(8) for true and certified copies reflect the existing legislation. The Law

Society suggests that a new clause 217(8)(e) is added to include the person's current treatment or safety plan.

Recommendations

3.178 The Law Society recommends amending clause 217 to:

(a) consolidate clause 217(2) and (5) to provide clarity; and

(b) insert a new clause 217(8)(e) to include the person's current treatment or safety plan.

Nāku noa, nā

David Campbell
Vice President