

Transforming our Mental Health Law

A public discussion document

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Foreword

We are on a pathway to transforming New Zealand's approach to mental wellbeing, building on the agenda set by *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (He Ara Oranga). *Kia Manawanui: Long-term pathway to mental wellbeing* sets out our direction and actions for transformation. This includes ensuring our mental health law reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the current Act) is almost 30 years old and is not working the way it should. It is not adequately supporting improved mental health outcomes or the wellbeing of individuals and is contributing to significant inequities.

The current Act has been widely criticised for being out of step with Te Tiriti o Waitangi and New Zealand's other domestic and international human rights commitments. It has also been criticised for not supporting modern approaches to care and treatment. These matters were highlighted in *He Ara Oranga*. The Government has listened to these significant concerns, and we have committed to repealing and replacing the Mental Health Act.

Repealing and replacing the current Act is an opportunity which will require us to make choices about important rights and the values that underpin mental health legislation in New Zealand. I know there are diverse perspectives on these topics, and we need to carefully consider the complex ethical, legal and policy issues.

We want to be sure we get it right, and we need to develop solutions to these issues in partnership with people with lived experience of the current Act and their whānau and families, particularly Māori who experience higher rates of compulsory treatment and seclusion. We also need to hear the perspectives of clinicians and service providers who care for people under the Mental Health Act every day.

In July 2019, the Government agreed to principles to guide the process for developing new legislation. It is critical that recommendations for new legislation align with these principles:

- maintaining consistency with Te Tiriti o Waitangi
- taking a human rights approach
- encouraging maximum independence, inclusion in society and the safety of individuals, their whānau and the community
- improving equity of care and treatment
- taking a recovery approach to care and treatment
- providing timely service access and choice
- providing the least restrictive mental health care options
- respecting family and whānau.

It is apparent the current Act is resulting in unfair, unjust and avoidable worse outcomes for Māori, Pacific, those with disabilities and those living in areas of high deprivation. Addressing these issues through new legislation is essential to improving care and treatment for those who are currently compulsorily assessed and treated in New Zealand.

The aim of repealing and replacing the current Act is to create new legislation that protects and respects human rights, implements the principles of Te Tiriti and improves equity. If these objectives are met, the new legislation will improve outcomes for people in their most vulnerable states and for those who continue to experience systemic inequities under the current framework. Your feedback on the topics in this document will help with the development of new legislation that meets these goals.

Hon Andrew Little
Minister of Health

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Preamble:

Te ao Māori perspective

The repeal and replacement of the current Mental Health (Compulsory Assessment and Treatment) Act 1992 (the current Mental Health Act) provides a unique opportunity to transform and rethink mental health law in Aotearoa New Zealand. This includes the opportunity to find the right balance for us as a nation made up of many peoples, and to support a te ao Māori perspective in our new legislation to provide appropriate care, support and structures for all New Zealanders.

The interconnectedness and interrelationship of all living and non-living things, both tangible and non-tangible, forms the basis of te ao Māori (the Māori world view). Though not exhaustive, this includes connections to the whenua (land); taiao (broader environment); tīpuna (ancestors); wairua (spiritual); hinengaro (mental); tinana (physical); whānau, hāpu, iwi (extended families) and te reo (Māori language). These inherent sources of wellbeing provide strength, affirmation and reinforcement of cultural identity that enable tāngata whai ora to reclaim and express their right to simply 'being Māori'.¹

Application of the current Mental Health Act does not represent or adequately support te ao Māori. Instead, the application of the Act can isolate people as individuals, which may result in disconnection from whānau, whenua, taiao and tīpuna at times when these connections are most needed. Experiences of compulsory mental health treatment under the current Mental Health Act can weaken a person with respect to the health of their wairua, hinengaro and tinana.

Key opportunities for change with creating new legislation include addressing the over-representation of tāngata whai ora in compulsory mental health assessment and treatment and describing and reinforcing, in legislation, the Crown's Te Tiriti o Waitangi (Te Tiriti) obligations to Māori to improve Māori mental health and addiction outcomes. The new Act is intended to enable systemic changes to services and practices that support and promote mental wellbeing for Māori and for all peoples of Aotearoa New Zealand. As Tā Mason Durie recently articulated:

Whenua grounds us.
Te taiao defines us.
Raukaha helps us.
Te hononga unites us.
Hautūtanga guides us.
Te ao whānui extends us.
Te Tiriti guarantees us.
Rangatiratanga assets us. (*Durie 2021*)

¹ *Te Reo Hāpai The Language of Enrichment*, A Māori language glossary for use in the mental health, addiction and disability sectors, Nā Keri Opai | Te Pou o te Whakaaro Nui (nd)
<https://www.tepou.co.nz/resources/te-reo-hapai-the-language-of-enrichment-glossary>

Introduction

The aim of this discussion document

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the current Mental Health Act) sets out the circumstances in which people may be subject to compulsory mental health assessment and treatment. It is intended to be used as a last resort for people in a vulnerable and distressed state who are otherwise unable to engage with mental health treatment. Most people in Aotearoa New Zealand who access specialist mental health and addiction services will not be placed under the current Mental Health Act. In 2019, 5.8 percent of people using specialist mental health and addiction services were placed under the current Mental Health Act (Ministry of Health 2021).

When the current Mental Health Act was passed nearly 30 years ago, it was considered world-leading legislation. However, in more recent years it has been widely criticised for not keeping pace with new and emerging approaches to care and for being out of step with Aotearoa New Zealand's international human rights commitments. In recognition of these concerns, the Government has committed to repealing and replacing the current Mental Health Act with new legislation that aligns to the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The CRPD is an international human rights treaty intended to protect the rights and dignity of people with disabilities. Mental illness (impairment) is included in the description of disabilities under Article 1.²

This discussion document sets out the key topics identified so far that need to be considered in developing this new legislation. It is important to acknowledge that the legislation is just one part of a whole system, and there are many factors that affect a person's mental health and wellbeing that cannot be addressed by legislation, such as expanding and improving access to mental health and addiction services. While these are important topics and issues to consider, they are not part of this discussion document. There will be other opportunities to contribute to the work on the wider transformation of the mental health and addiction system.

The aim of repealing and replacing the current Mental Health Act is to create new legislation that protects and respects human rights, implements the principles of Te Tiriti and improves equity. If these objectives are met, the new legislation will improve outcomes for people in their most vulnerable states and for those who continue to experience systemic inequities under the current framework. Your feedback on the topics in this document will help the Government develop a new Mental Health Act that meets these goals.

² The purpose of the CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all 'persons with disabilities' and to promote respect for their inherent dignity. 'Persons with disabilities' include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

The commitment to new legislation

In December 2018, the Government Inquiry into Mental Health and Addiction released *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)*. *He Ara Oranga* called for a new approach to mental wellbeing in Aotearoa New Zealand, one that emphasises wellbeing and community, more prevention and increased early intervention, expanded access to services, more treatment options, treatment closer to home and more cross-government and sector action/s.

He Ara Oranga included a recommendation to repeal the current Mental Health Act and replace it with legislation that 'reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment' (recommendation 34). In May 2019, the Government formally responded to *He Ara Oranga's* recommendations, including agreeing to repeal and replace the current Mental Health Act.

Since 2019, the Ministry of Health (the Ministry) has progressed improvements to the current legislation, alongside work to understand the issues to be addressed in creating new mental health legislation.

In September 2020, the Ministry published new guidelines to the current Mental Health Act. These guidelines promote the protection of the rights of people receiving compulsory mental health treatment by clarifying the responsibilities of mental health services and clinicians and offering guidance on how sections of the Act can be administered in line with both Te Tiriti and human rights principles.

In March 2021, a Mental Health (Compulsory Assessment and Treatment) Amendment Bill was introduced for consideration in Parliament. This Bill seeks to improve the protection of individual rights and the safety of both patients and the public. A critical feature of the Bill is the elimination of indefinite treatment orders, a change called for in *He Ara Oranga*. If passed into law, this Bill will enable changes to the current Mental Health Act to help it work better while the consultation and process to develop new legislation is underway.

With the implementation of revised guidelines and the progression of the Bill underway, it is now time to engage in discussions on the key issues involved in new mental health legislation.

Having your say

You are invited to give feedback on the whole of this discussion document or on select parts you are most interested in or affected by. In addition to responding to issues

raised in this document, you may have other views and concerns that we have not captured in it, and we encourage you to tell us about these views and concerns.

This document is open for submissions until **28 January 2022**. You may use assistance to prepare and submit your submission.

You can provide feedback by:

- making an online submission at **consult.health.govt.nz**
- answering the questions in the consultation document and emailing your responses to **mhactreview@health.govt.nz**
- answering the questions in the consultation document and sending a hard copy to:
 - Consultation: Transforming mental health law in Aotearoa New Zealand
Ministry of Health
PO Box 5013
Wellington 6140

Navigating the document

The document has been divided into nine parts.

Parts 1 and 2 provide background information about the current Mental Health Act, reasons for repealing and replacing it and the vision for future legislation as a part of the overall transformation of mental health and addiction services.

Parts 3 through 9 each focus on specific topics for discussion. Each part describes what its topic is about and what the current Mental Health Act does or does not do with respect to that topic. Each part goes on to provide information to help you better understand the topic and the questions, a summary of relevant feedback received in the past, and key questions we would like your feedback on.

The topics covered are:

- embedding Te Tiriti and addressing Māori cultural needs (**Part 3**)
- defining the purpose of mental health legislation, including adopting a human rights approach and considering whether compulsory mental health treatment should ever be allowed (**Part 4**)
- defining the circumstances and criteria for when compulsory mental health treatment, if permitted, might be appropriate (**Part 5**)
- ensuring people are able to use appropriate tools to support them to make decisions about their care and treatment (**Part 6**)
- considering the use of prohibition or seclusion, restraint, or other restrictive practices (**Part 7**)
- addressing the needs of specific populations such as people from different cultural backgrounds, family and whānau, children and youth, disabled people and people within the justice system (**Part 8**)
- ensuring people's rights are protected and monitored (**Part 9**).

Three appendices are also included at the end of this document to provide additional background information.

- **Appendix A** provides an overview of the current Mental Health Act and gives a more detailed overview of how the current legislation functions.
- **Appendix B** discusses approaches to compulsory treatment in other countries, summarising how the legislation in several comparable countries handles compulsory mental health treatment.
- **Appendix C** gives an overview of key human rights laws of Aotearoa New Zealand and the different international agreements Aotearoa New Zealand has signed regarding human rights.

Seeking support when making your submission

Sometimes people experience unexpected emotional or psychological effects as a result of making a submission about something that is important to them. If you intend to make a submission, we recommend you arrange to have a support person or network who is/are aware of your submission and be ready to help you if difficulties arise.

If you need support, you can **call or text 1737**. This helpline service is completely free and is available 24 hours a day. You'll get to talk or text with a trained counsellor.

Official Information Act

Please note that submissions are official information under the Official Information Act 1982 (the Act). Copies of your submission may be requested under the Act and may need to be released. If your submission contains information that you believe should be withheld, please make it clear in your submission what this content is and why you think it should be withheld. Any request for withholding information on the grounds of confidentiality or for any other reason will be determined in keeping with the Act. Personal health information about identifiable individuals will generally be withheld due to the private and sensitive nature of this information.

What will happen next

Your feedback and responses to the questions in this document are an important part of the process to develop new mental health legislation fit for Aotearoa New Zealand. After the closing date for submissions, an independent external organisation will review all submissions received and analyse them to understand the common themes and preferences for what new legislation should look like. This will help the Ministry

develop recommendations for new legislation, which we will present to the Government for consideration.

Once the Government has agreed to the policy for new legislation, a Bill will be created and introduced to the House. This process can take some time, especially for complex legislation which this is likely to be.

For more information on the legislative process and all of the steps involved, please see the webpage "How a bill becomes law" on the New Zealand Parliament website at: www.parliament.nz/en/visit-and-learn/how-parliament-works/how-laws-are-made/how-a-bill-becomes-law/.

Part 1:

Where we are now

1.1 How we got here

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the current Mental Health Act) sets out the rules for when the government may intervene in a person's life to provide mental health treatment against their will.

From the 1960s, mental health treatment in Aotearoa New Zealand began to shift away from psychiatric hospitals towards community-based care, with a greater emphasis on people's role in their own recovery. This culminated with the downsizing and closure of many of the country's psychiatric hospitals in the 1990s, a period that is now widely considered as the last time our mental health and addiction system underwent major transformation.

The current Mental Health Act represented a step forward, with its requirement for care to be provided in the least restrictive manner and a focus on encouraging community care over hospital care whenever possible. Importantly, the Act included recognition and protection of patient rights.

The intent of the current Mental Health Act was to ensure that mental health treatment could be provided to those who needed it, in the least intrusive and restrictive way, and to define and better protect the rights of compulsory treatment patients. For the first time, assessment and treatment could be provided in people's own homes, with access to inpatient facilities as a back-up.

In 1999, the current Mental Health Act was amended to include a requirement for mental health services to consult with families and whānau unless a clear reason existed not to. This amendment was the last significant update made to the current Mental Health Act. In practice, however, it has become clear that this amendment has not gone far enough to ensure family and whānau are included in a person's recovery process, something that is discussed in more detail below in **Part 8.2: Respecting family and whānau**.

1.2 How the current Mental Health Act works

This section provides a brief overview of the process a person experiences when placed under a compulsory treatment order under the current Mental Health Act. For more details about the process and requirements under the current Mental Health Act, see **Appendix A**.

1.2.1 Who can be placed under the current Mental Health Act

A person must have a 'mental disorder', as defined by the current Mental Health Act, before they can be subject to compulsory assessment or treatment. The Act defines 'mental disorder' as meaning that a person has:

- 'an abnormal state of mind (whether of a continuous or intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition of such a degree that it –
- (a) poses a serious danger to the health or safety of that person or of others; or
 - (b) seriously diminishes the capacity of that person to take care of himself or herself'.

The Act currently applies to a person of any age, including children.

For more information on the definition of mental disorder under the current Mental Health Act, see **Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992** (Ministry of Health 2020a).

1.2.2 The process for the current Mental Health Act

The compulsory assessment and treatment process begins with an initial assessment by a mental health practitioner (usually a psychiatrist, medical practitioner or nurse practitioner). If the practitioner believes the person fits the statutory criteria, the person will become subject to the current Mental Health Act and will receive a further assessment accordingly. The process for moving to that stage involves the mental health practitioner issuing a certificate of their initial assessment confirming that further assessment is necessary and someone (such as a family or whānau member or other health professional) making an application for further assessment under the current Mental Health Act.

1.2.3 Compulsory assessment

Compulsory assessment can take place in either a community setting or hospital setting. There are two periods of compulsory assessment. The first period of assessment is for up to five days. The second period can last up to 14 days.

During the assessment period, a person must receive the treatment that their responsible clinician (the health professional in charge of the person's care and treatment) prescribes. At any stage during the assessment, the responsible clinician may release the person from the assessment at any time.

Following the first two assessment periods, if a person's responsible clinician is of the opinion the person is not fit to be released from compulsory care, the responsible clinician can apply to the Family or District Court to place the person under a compulsory treatment order.

At any time during the compulsory assessment period, the person (or someone acting on their behalf) can request that the District Court review their condition to decide whether it is appropriate for them to continue to be assessed under the current Mental Health Act. A judge makes this decision based on information from clinicians.

1.2.4 Compulsory treatment

There are two types of compulsory treatment orders: one for treatment in the community and the other for treatment in an inpatient unit. A person's responsible clinician can convert an inpatient treatment order into a community treatment order at any time. That clinician may also let a person leave the inpatient unit for treatment in the community for up to three months.

During the first month of compulsory treatment, a person must receive the treatment that their responsible clinician prescribes. After that, the person must consent to treatment in writing. However, the current Mental Health Act allows for treatment to be given without consent if another psychiatrist (who has been appointed by the Mental Health Review Tribunal) considers the treatment to be "in the interests" of the patient.

1.2.5 What compulsory treatment means for a person

While the current Mental Health Act is only used for a small proportion of people who receive specialist mental health and addiction services, it can have a significant effect on the lives of those who experience it.

For an individual, a compulsory treatment order, whether for inpatient or community treatment, limits their right under the New Zealand Bill of Rights Act 1990 to refuse medical treatment. It can require a person to accept medication or other mental health treatment. Under the current Mental Health Act, the inability to refuse treatment is absolute for the first month of a compulsory treatment order. After the first month, a person technically has the ability to refuse a particular treatment or has the right to consent to the treatment. However, if a psychiatrist (who is not the treating practitioner) provides a second opinion agreeing with the treating practitioner that a particular treatment is in the best interest of the patient, the person's refusal to consent to the treatment can be overridden and the person can be required to continue to receive the treatment. This process, including concerns about how it is used, is discussed further in **Part 9.2: Challenging clinical decisions**.

It is important to note that a compulsory treatment order under the current Mental Health Act only relates to mental health treatment and does not limit a person's right to refuse other health treatment.

A person who is under an inpatient compulsory treatment order not only has their right to refuse medical treatment limited but also experiences a form of detention because they are required to remain in hospital, which is a limitation on their freedom of movement. The current Mental Health Act also permits the use of seclusion for people under an inpatient compulsory treatment order. Seclusion is where a person is placed alone in a locked room that they cannot freely exit. The topic of seclusion is discussed further in **Part 7: Seclusion, restraint and other restrictive practices**.

A person who is under a community compulsory treatment order is not detained the way a person under an inpatient order is, but there are limitations on their lives while they receive their treatment in the community setting. This can include requirements to allow community mental health team workers to enter their home to administer medications and requirements to attend treatment appointments at specific locations, which can involve travel for those who live in rural areas. There can also be limitations placed on a person's ability to travel without first seeking approval from their treatment team and/or developing an advance plan for any desired travel, including a plan for how their treatment will be managed.

Beyond the limitations on personal freedoms, including the right to refuse medical treatment and make decisions for oneself, there is stigma associated with being under a compulsory treatment order. We have heard that this stigma can lead to discrimination. The stigma may be experienced subtly or overtly, and it may affect housing, employment or social opportunities.

1.3 Why the current Mental Health Act is being replaced

He Ara Oranga states that the current Mental Health Act is out of date, inconsistent with Aotearoa New Zealand's obligations under international law, and sometimes results in trauma and harm to people receiving compulsory treatment (Government Inquiry into Mental Health and Addiction 2018a).

1.3.1 Lack of evidence of effectiveness

Around 10,000 people each year are subject to some part of the compulsory assessment and treatment process under the current Mental Health Act (Ministry of Health 2021). However, as outlined throughout this discussion document, the current Mental Health Act does not appear to be supporting improved mental health outcomes or the wellbeing of individuals overall and is instead contributing to significant inequities.

The use of compulsory treatment orders varies by district health board (DHB), even after considering the difference in population sizes, and as discussed below is inequitably used with respect to Māori and Pacific peoples. Almost half of all people on a compulsory treatment order are on an indefinite treatment order (a compulsory treatment order with no end date).

If the current Mental Health Act was truly protecting the rights of individuals and supporting improved outcomes, we would expect consistent use across DHBs in a manner proportionate to population size, equitable representation of Māori and Pacific peoples compared with non-Māori and non-Pacific peoples, and much smaller numbers of people on indefinite treatment orders. Further, people would experience a supportive and empowering process.

1.3.2 Evidence of inequities under the Act

Any issue that predominantly affects one or some groups more than others is an equity issue. The substantial differences in the way the current Mental Health Act is working for our different population groups provides a strong rationale for significant legislative reform. In particular, Māori, Pacific peoples and disabled people experience a range of inequities under the Act, which are made clear in both the statistics and people's descriptions of their experiences.

Equity issues require special treatment, including targeted action based on engaging with, listening to and partnering with the people who are most affected. In addition, issues where Māori are disadvantaged or harmed need to be carefully considered, designed and implemented, drawing on the strength of the special relationship that the Crown has with Māori under Te Tiriti o Waitangi.

Inequalities and inequity in health

The Ministry's definition of equity is:

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

This definition of equity was signed-off by Director-General of Health, Dr Ashley Bloomfield, in March 2019.³

We usually refer to differences in health experience occurring between population groups as 'health inequalities'. A 'health inequity' is an inequality that we can attribute to social, cultural and/or economic factors rather than biomedical ones.

Inequalities and inequity in health occur between groups because of a range of well-recognised socioeconomic, cultural and biological factors. The most common factors are sex, age, social deprivation, ethnicity and education.

Inequities are not random but are typically due to structural factors present in society and the local community that cannot be explained by biomedical differences between population groups. This means their causes are often complex and multifaceted and are outside the scope of the health system to address on its own.

Current statistics show that Māori are significantly more likely to be subject to compulsory mental health treatment under the current Mental Health Act than non-Māori. In 2020, Māori were:

- 3.7 times more likely than non-Māori to be subject to a community treatment order
- 3.2 times more likely than non-Māori to be subject to a hospital inpatient treatment order
- 5.1 times more likely to be secluded than non-Māori.⁴

Like Māori, Pacific peoples also have higher rates of compulsory mental health treatment under the current Mental Health Act. Provisional statistics show that, in 2020, Pacific peoples were:

- 1.5 times more likely than non-Pacific peoples, to be subject to a community treatment order
- 1.4 times more likely than non-Pacific peoples to be subject to a hospital inpatient treatment order
- secluded at similar rates as non-Pacific peoples.⁵

³ For more information, see the Achieving equity webpage on the Ministry of Health website at: www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity.

⁴ Provisional data extracted from PRIMHD on 1 July 2021, with manual data for inpatient/section 30 orders from Counties Manukau DHB, and manual data from Southern, Waitematā and Whanganui DHBs for seclusion.

⁵ Provisional data extracted from PRIMHD on 1 July 2021, with manual data for inpatient/section 30 orders from Counties Manukau DHB, and manual data from Southern, Waitematā and Whanganui DHBs for seclusion.

1.3.3 Culture of risk aversion

Concern has been raised that, under the current Mental Health Act, practitioners have developed a culture of risk aversion and defensive practice. *He Ara Oranga* indicates this may be the result of some high-profile cases and investigations raising questions about the decisions of practitioners, including whether someone who was not placed under compulsory treatment should have been (Government Inquiry into Mental Health and Addiction 2018a). Practitioners are seen to be making decisions in a way that will avoid risk rather than with regard to whether the decision is truly in the best interest of the patient or whether care can be effectively delivered in a less restrictive manner (Government Inquiry into Mental Health and Addiction 2018a).

He Ara Oranga recommended engaging in a national conversation to reconsider beliefs and attitudes about risk to address the concerns about increasing levels of risk-based practice (Government Inquiry into Mental Health and Addiction 2018a).

1.3.4 Inconsistency with human rights law

Many people and organisations have criticised the use of compulsory mental health treatment as failing to uphold people's rights, including the rights contained in Te Tiriti. This includes the universal rights to autonomy and freedom from interference contained in Aotearoa New Zealand and international human rights laws. An overview of the relevant human rights law and human rights international agreements that apply in Aotearoa New Zealand is provided in **Appendix C**.

In 2017, the Ministry undertook consultation focused on **how well the current Mental Health Act upholds human rights** (Ministry of Health 2017a, b, c). Overwhelmingly, responses to this consultation indicated that people believe the Act is inconsistent with international human rights agreements and with contemporary thinking about mental health and human rights. Notable inconsistencies identified by submitters were the Act's medical model of mental health (versus a social model of mental health and disability), substituted (versus supported) decision-making, and the Act's lack of recognition of legal capacity.

Part 2: Creating a new approach

2.1 Transforming mental health and addiction services

We are on a journey to transform Aotearoa New Zealand's approach to mental wellbeing, building on the vision set by *He Ara Oranga* (Government Inquiry into Mental Health and Addiction 2018a). This transformation includes repealing the current Mental Health Act and replacing it with legislation that 'reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment' (recommendation 34). In order for the changes that are under way to be successful, we need to build on the strengths of our existing systems and services and create new and different approaches to supporting mental wellbeing.

Significant steps have already been taken to improve mental wellbeing in Aotearoa New Zealand, supported by substantial investment. Government has put in place the foundations for transformation, including the establishment of the Suicide Prevention Office in October 2019 and the Mental Health and Wellbeing Commission in February 2021.⁶ We have expanded access and choice of primary mental health and addiction supports (including kaupapa Māori, Pacific, rainbow and youth services), boosted crisis services, developed initiatives to prevent suicide and support people bereaved by suicide, strengthened specialist alcohol and other drug services, and expanded and enhanced school-based health services.

These initiatives are already making a difference to thousands of people who would otherwise not have had access to support. However, we recognise that mental wellbeing requires more than mental health and addiction services, and it is much wider than a health issue. Changes to the current Mental Health Act are one part of this greater vision of a transformed approach to mental wellbeing in this country. The Ministry is also planning for the development of a Mental Health and Addiction System and Services Framework. This framework will be developed in alignment with the principles of the new legislation to ensure it supports the practice change required by the new legislation.

⁶ For more information about the commission, see the Mental Health and Wellbeing Commission website at: www.mhwc.govt.nz.

This approach to achieving overall transformation is outlined in *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* (*Kia Manawanui*), released in September 2021. Consistent with *Whakamaaua: Māori Health Action Plan 2020–2025* (Ministry of Health 2020c), *Kia Manawanui* describes an overarching vision of pae ora – healthy futures. Pae ora encompasses three elements: mauri ora (healthy individuals); whānau ora (healthy families) and wai ora (healthy environments). Creating new legislation can support pae ora by supporting self-determination and enhancing mana, encouraging whānau involvement and strengthening recognition of Te Tiriti and cultural needs.

2.2 The future vision for legislation

The recommendation in *He Ara Oranga* gives us a starting place for a vision of future legislation. It flags that, at a minimum, the legislation needs to reflect a human rights-based and recovery approach to care, promote supported decision-making and minimise compulsory care and coercion. We also know that any new legislation must recognise Te Tiriti and support the rights of Māori as tangata whenua, consistent with the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). It must also align with the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

2.2.1 Grounding in te ao Māori

We have a unique opportunity to completely reimagine what mental health legislation in Aotearoa New Zealand is, what it is used for and when, and how it can support people to be holistically well. With this blank slate, we can approach the design of new legislation from a te ao Māori perspective. This will ensure all people are viewed and treated in a holistic manner.

This approach will be a significant shift away from a Western, medicalised approach to mental health care and treatment and mental health legislation. People will be at the centre of their care and treatment, and whānau will not be kept on the outside.

2.2.2 Guiding principles

First and foremost, new legislation must be guided by, and reflect, Te Tiriti and its principles. **Part 3: Embedding Te Tiriti o Waitangi and addressing Māori cultural needs** below provides more discussion about the principles of Te Tiriti and how they are applied in a health context.

In addition, in July 2019, the Government agreed to a specific set of high-level principles (the Government principles) to guide the process for developing new legislation. The agreed principles are:

- maintaining consistency with Te Tiriti
- taking a human rights approach
- encouraging maximum independence, inclusion in society and the safety of individuals, their whānau and the community
- improving equity of care and treatment
- taking a recovery approach to care and treatment
- providing timely service access and choice
- providing the least restrictive mental health care options
- respecting family and whānau.

Any recommendations for new legislation need to align to these principles. For more information about what these principles mean, please see **the *Mental Health Act Reform Cabinet Paper*** (Clark 2019).

2.2.3 Shifting from a risk-based approach

The current Mental Health Act is a risk-based model of mental health legislation, as a key part of the definition of ‘mental disorder’ is whether a person poses a serious risk to themselves or others. *He Ara Oranga* clearly indicates the need to move away from risk-based approaches to care and treatment of people in vulnerable and distressed states (Government Inquiry into Mental Health and Addiction 2018a).

The development of new legislation enables us to consider an approach that moves away from embedding concepts of risk into the legislation and away from embedding risk assessments into the processes the legislation mandates. New legislation can support mental health services to shift their focus from reactive risk management to proactively supporting the safety of people, with the concept of safety defined from the perspective of the person rather than the practitioner.

2.2.4 A better future for all

Replacing the current Mental Health Act provides us with the first opportunity in a generation to create legislation, grounded in te ao Māori, that will encourage maximum independence and social inclusion for all people. We can create new mental health legislation that respects family and whānau, recognises Te Tiriti and improves equity.

It is important to recognise that the legislation will be just one part of the wider mental health services and support system for people and whānau in Aotearoa New Zealand. As such, the legislation should support treatment and services for people in a

vulnerable and distressed state and should be used as a last resort: it should not drive a person's ability to access treatment and services.

The care and treatment provided through legislation should be delivered in a way that recognises a person's strengths rather than minimising perceived deficits. The new legislation should promote safety of people, whānau and the community. We have the opportunity to set in place clear guidelines for minimising restrictive practices and for supporting specific populations.

It must also be recognised that some parts of providing support to a person in a vulnerable and distressed state may fall outside the boundaries of what mental health legislation can do. A person's mental wellbeing can be influenced by a number of factors, including whānau and social dynamics, living environment, financial stability, employment and housing. Further, we know that the delivery of quality, affordable and timely mental health care and treatment relies on a whole system of providers and services operating efficiently and effectively. This is beyond the scope of what the new legislation can do. These topics are therefore not covered in this document, which focuses on the future of mental health legislation in Aotearoa New Zealand with a grounding in te ao Māori and human rights.

However, these factors are very important considerations in ensuring the best mental health and wellbeing outcomes possible for all people in Aotearoa New Zealand. As such, *Kia Manawanui* provides a vision and direction for the overall transformation of mental health care in Aotearoa New Zealand that considers those factors (see **Part 2.1: Transforming mental health and addiction services** above for more information on *Kia Manawanui*).

Part 3: Embedding Te Tiriti o Waitangi and addressing Māori cultural needs

3.1 What this part is about

In this part, we ask you to consider what is required to ensure Te Tiriti is properly recognised in any new legislation and given effect any time the legislation is used, as well as what is needed in the legislation to support Māori cultural needs.

Te Tiriti is our country's foundational document and establishes the relationship between Māori and the Crown. This means that all of the government's legislation and policy must have special regard for the principles of Te Tiriti and for Māori as the Crown's Te Tiriti partner. Ensuring our new legislation adequately supports the delivery of culturally appropriate care will be an important part of improving the way new mental health legislation promotes the principles of Te Tiriti and the Crown-Māori relationship.

This part relates to Te Tiriti principles of:

- tino rangatiratanga
- partnership
- active protection
- options
- equity

and the Government's principles as set out in the *Mental Health Act Reform Cabinet Paper* (Clark 2019) of:

- maintaining consistency with Te Tiriti
- improving equity of care and treatment
- providing timely service access and choice.

3.1.1 What the current legislation does or does not do

The current Mental Health Act requires all powers and proceedings under the Act to be carried out with proper recognition of the importance and significance to the person of that person's ties with their 'family, whānau, hāpu, iwi and family group' and with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs' (sections 5(2) and 65). It does not, however, formally acknowledge Te Tiriti, and does not have clear requirements around how practitioners must give proper respect for cultural and ethnic identity. For example, there are no requirements under the current Mental Health Act for a person to receive a cultural needs assessment when the compulsory assessment or treatment process is started.

3.2 What you might want to know

3.2.1 Te Tiriti o Waitangi principles

Progressing Māori interests and values under Te Tiriti o Waitangi requires bravery, persistence and working with aroha. It has never been about Te Tiriti rights, it's always been about the rightness that comes from people accepting their obligations to each other (Moana Jackson, interview, 2017).⁷

Te Tiriti anticipates mutual benefits for Māori and the Crown and requires genuine partnership between the two parties to share decision-making that affects whānau, hāpu and iwi. Te ao Māori (Māori world view) and the voices of tangata motuhake and whānau should be kept at the forefront of policy and legislation development and education and training of the whole mental health and addiction workforce.

The Ministry, as steward and kaitiaki (guardian) of our country's health and disability system (article I of Te Tiriti), has a responsibility to enable Māori to exercise authority over their health and wellbeing (article II of Te Tiriti) and to achieve equitable health outcomes for Māori (article III), in ways that enable Māori to live and flourish as Māori (the Ritenga Māori declaration).⁸ Under Te Tiriti, the Ministry and all publicly funded health services are obliged to acknowledge and apply Te Tiriti articles and principles in their policies, protocols and practices.

⁷ Of Ngāti Kahungunu and Ngāti Porou descent, Moana Jackson is a Māori lawyer and director of Ngā Kaiwhakamarama i Ngā Ture (the Māori Legal Service).

⁸ The Ritenga Māori declaration (often referred to as the 'fourth article') was drafted in te reo Māori and read out during discussions with rangatira about Te Tiriti at the time of the development of Te Tiriti. The Ritenga Māori declaration provides for the protection of religious freedom and traditional spirituality and knowledge.

The principles of Te Tiriti are described for the context of health services in *Whakamaua: Māori Health Action Plan 2020–2025* (Ministry of Health 2020c).

- Tino rangatiratanga (self-determination) underpins the principles identified in Te Tiriti. It is often translated as 'self-determination' or 'sovereignty'. It means that Māori are guaranteed self-determination and mana motuhake (the right to be Māori and to live on Māori terms in accordance with Māori philosophies, values and practices) in the design, delivery and monitoring of health and disability services.
- 'Partnership' is recognised as a relationship between the Crown and Māori, in which both parties act with respect towards one another, work together and are flexible about different structures where organisations are not meeting the needs of one another. Partnership requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the health and disability system for Māori.
- 'Active protection' requires the Crown to act, to the greatest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its partner in Te Tiriti are well informed on the extent and nature of both Māori health outcomes and efforts to achieve Māori health equity.
- 'Options' requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- 'Equity' requires the Crown to commit to achieving equitable health outcomes for Māori. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.

These principles are interrelated and aim to strengthen effective health pathways, equitable outcomes and overall satisfaction within the health and disability system for all.

3.2.2 Embedding Te Tiriti o Waitangi and addressing Māori cultural needs

Culture strongly affects how we think about and perceive our and others' internal lives, relationships and experiences. It contributes to what we consider to be acceptable/normal or bad/different, including our understanding of mental illness and the symptoms of mental distress. This has significant implications for concepts and behaviours, such as help-seeking, care, treatment and recovery. A strong cultural identity has been linked to positive mental health in research, including some specific to rangatahi Māori in Aotearoa New Zealand (Williams, Clark, and Lewycka, 2018).

As described in **Part 1.3.2: Evidence of inequities under the Act** above, Māori are significantly more likely to be subject to compulsory mental health treatment and seclusion under the current Mental Health Act, and Te Tiriti creates specific obligations for the Crown to ensure equitable outcomes for Māori. Ensuring new mental health legislation addresses the specific cultural needs of Māori will be an important part of embedding Te Tiriti principles of tino rangatiratanga, active protection, options, and equity into the legislation, while a collaborative process to determine what culturally appropriate care looks like will support embedding Te Tiriti principle of partnership. If done appropriately, legislation that supports Māori cultural needs can also ensure better support for all people.

Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Ministry of Health 2020a) encourage the use of cultural assessments and offer examples of different cultural models of care, such as Te Whare Tapa Wha,⁹ that might be appropriate for different people receiving compulsory mental health treatment. However, while the Ministry monitors the guidelines, directions in the guidelines do not have the same force as requirements in legislation or regulation.

Mental health services are encouraged to have kaupapa Māori models of care available for Māori under the current Mental Health Act and to use traditional Māori processes, such as mihi whakatau, to better welcome and support Māori individuals who are coming into care. However, while encouraged, these specific practices are not currently required by any legislation.

3.2.3 Waitangi Tribunal Wai 2575 Inquiry

In 2016, the Waitangi Tribunal commenced its investigation into issues of national significance relating to health services and health outcomes for Māori (Wai 2575). Wai 2575 is being undertaken as a staged process, with stage one of the inquiry focusing on the legislative and policy framework of the primary health care system. The Waitangi Tribunal has published its findings and recommendations on stage one (*Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*, Waitangi Tribunal 2019).

Recommendations include changes to legislation and policies to give effect to Te Tiriti principles (tino rangatiratanga, partnership, active protection, options and equity), with a clear objective for the health sector to achieve equitable outcomes for Māori.

⁹ Te whare tapa whā is a model of the four dimensions of wellbeing developed by Sir Mason Durie in 1984 to provide a Māori perspective on health. The four dimensions are: **taha tinana** (physical wellbeing), **taha hinengaro** (mental wellbeing), **taha wairua** (spiritual wellbeing), **taha whānau** (family wellbeing). With four walls, the whareniui (meeting house) is a symbol of these four dimensions. The whareniui's connection with the **whenua** (land) forms the foundation for the other four dimensions.

Stage two will be structured in two parts covering three priority areas. Part one will focus on Māori with disabilities. Part two will focus on Māori mental health (including suicide and self-harm) and issues of alcohol, tobacco and substance abuse. While the findings from stage two will be important for the transformation of mental health and addiction services, it is not necessary to wait to begin addressing known issues as we develop the new legislation.

3.3 What we have heard

Recognition and incorporation of Te Tiriti is vital in the context of the new Mental Health Act, given that Māori continue to be disproportionately placed under the current Act, receiving community compulsory treatment orders at nearly four times the rate of non-Māori.

Māori and other respondents to the Inquiry into Mental Health and Addiction were clear that Te Tiriti must be at the heart of all solutions relating to mental health and addiction.

Overwhelmingly, submissions from Māori said that the health and wellbeing of Māori requires recognition of indigeneity and affirmation of indigenous rights. They argued that our approach to mental health needs to acknowledge the Tāngata Whenua status of Māori under Te Tiriti o Waitangi ...

(Government Inquiry into Mental Health and Addiction 2018a)

Submitters to the Inquiry into Mental Health Addiction were clear that Te Tiriti must be at the heart of all solutions relating to mental health and addiction. They also described instances where the enforcement of compulsory treatment orders transgress tikanga, for example, a mental health service practitioner attending a tangi to ensure a whānau member was taking their medications.

At a 2015 hui to discuss Māori tangata whai ora experiences of receiving treatment under the current Mental Health Act, participants described their experience of acute mental health services as 'restrictive' and 'disempowering' and expressed their sense that the treatment they received was more closely aligned with the clinicians' needs than their own. They also described experiencing overt discrimination in the community, such as disproportionately harsh treatment by police and being refused accommodation and employment due to the stigma that continues to surround community treatment orders (Baker 2015).

3.4 What we want to know from you now

3.4.1 What new legislation could do

Recognition of Te Tiriti in the new legislation could be written in many different ways. The legislation could explicitly reference Te Tiriti in its purpose and principles and require actions under the legislation to be undertaken in a manner consistent with Te Tiriti or with the principles or spirit of Te Tiriti. The legislation could set out specific requirements. It could also place specific duties on named individuals.

The legislation could include specific requirements regarding culturally-appropriate care for Māori. For example, it could require the use of specific Māori cultural practices as part of any compulsory mental health treatment processes.

To truly embed Te Tiriti, once any requirements are in legislation, they must also flow through to policy and operational policy, including funding, commissioning, monitoring and workforce development.

In whatever way the new legislation recognises Te Tiriti, it will be critical to ensure the language, requirements and expectations are clear for mental health providers and anyone else involved in the use of the legislation to ensure Te Tiriti is actually upheld and embedded into practices.

It is important to recognise that legislation itself will not resolve the inequities currently experienced by Māori under the Act. The legislation can provide a framework to support delivery of equitable care and treatment, however, wider systemic shifts as part of the overall transformation of mental health and addiction services will be critical to enable actual improvements in equitable outcomes for Māori.

3.4.2 Questions for you

- How can legislation help embed Te Tiriti o Waitangi?
- What kaupapa Māori principles should the legislation incorporate?
- What effect will embedding Te Tiriti o Waitangi into practices have for other population groups (for example, children, disabled people, etc)?

Part 4: Defining the purpose of mental health legislation

4.1 What this part is about

In this part, we will ask you about the purpose of mental health legislation in Aotearoa New Zealand. This includes thinking about how legislation should balance different human rights and whether legislation should ever allow a person to be forced to have mental health treatment (also known as compulsory treatment).

This part relates to Te Tiriti principles of:

- tino rangatiratanga
- active protection

and the Government principles as set out in the *Mental Health Act Reform* Cabinet Paper (Clark 2019) of:

- taking a human rights approach
- taking a recovery approach to care and treatment.

4.1.1 What the current legislation does or does not do

The long title of the current Mental Health Act provides an overview of the intended purpose of the Act:

An Act to redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

As discussed in **Part 1.2.1: Who can be placed under the current Mental Health Act**, a person can be given compulsory mental health treatment if they have a mental disorder as defined by the current Mental Health Act. This definition of mental disorder implies that, under the current Mental Health Act, concerns about the safety of an individual and others outweigh a person's right to make a choice about whether to accept or reject mental health treatment if that person also has an 'abnormal state of mind'. This has been criticised as a form of discrimination and inconsistent with human rights and a recovery approach to care.

The Mental Health Act currently does not:

- require informed consent to treatment
- require the need to determine whether a person has the capacity to give informed consent to treatment
- explicitly require people to be involved in decisions about their own treatment
- explicitly require compulsory treatment only as a last resort (although the Act is described as implicitly requiring a 'least restrictive' approach to treatment).

4.1.2 Human rights and compulsory treatment

People hold several essential human rights. Those established in Aotearoa New Zealand and international law (see **Appendix C**) include:

- the right to autonomy
- the right to life and liberty
- the right to be equal before the law and not be discriminated against
- the right not to be tortured or subject to cruel treatment.

In addition, the right to good health is set out in international law but not established in the laws of Aotearoa New Zealand.

The New Zealand Bill of Rights Act 1990 (the Bill of Rights) protects and promotes human rights and fundamental freedoms in Aotearoa New Zealand. Among others, this includes the right to refuse medical treatment, the right not to be detained (held) without good reason and the right not to be tortured or treated cruelly. However, the rights set out in the Bill of Rights can be limited by other laws where this is 'demonstrably justified in a free and democratic society'. For example, the current Mental Health Act limits a person's right to refuse medical treatment.

Within Aotearoa New Zealand and specifically within the context of health services, of which mental health services are a part, the Code of Health and Disability Services Consumers' Rights (the Code of Rights) establishes the rights of consumers and the obligations and duties of health care and disability services providers to comply with the Code of Rights. It is a regulation under the Health and Disability Commissioner Act 1994 and specifies 10 rights, which are described in **Appendix C**.

While the current Mental Health Act permits limitations on some rights as set out in the Bill of Rights and the Code of Rights, it does not eliminate rights, and it only limits those rights to the extent necessary and appropriate.

Internationally, the United Nations Committee on the Rights of Persons with Disabilities (the Disabilities Committee) has interpreted the CRPD (see **Appendix C**) as requiring countries to end detention and compulsory treatment based on mental illness or any other disability. Many individuals and organisations support this position.

In 2014, the Disabilities Committee reviewed Aotearoa New Zealand's compliance with the CRPD and expressed concern that the current Mental Health Act lacks human rights principles. It recommended that:

- the Government of Aotearoa New Zealand take immediate steps to ensure that no one is detained against their will, on the basis of actual or perceived disability, in any medical facilities (Article 14)
- all mental health services be provided on the basis of the free and informed consent of the person concerned (Article 12)
- the Mental Health Act be amended to align with the CRPD.

However, some United Nations bodies (including the Human Rights Committee and Subcommittee on the Prevention of Torture) have declared that certain types of coercive and compulsory practices can help protect a person's human rights in some situations. In particular, this may apply to the right to life of a person with severe mental health conditions. This perspective involves the concept that ending coercion and compulsion completely is not feasible (Gooding et al 2018), although these should only be used as a last resort and applied for the shortest amount of time appropriate, with adequate safeguards in place (Szmukler 2019).

Some people have suggested that completely banning compulsory treatment could result in individuals in a vulnerable and distressed state going untreated or being left to fall into the justice system. At this stage, we do not have enough information to predict whether this would happen in Aotearoa New Zealand and if so, to what extent.

Since signing the CRPD, many countries have updated their mental health laws to more closely align with a human rights approach, but they all continue to provide compulsory treatment in some circumstances. **Appendix B** outlines the legislative approaches that a range of other countries are taking around compulsory treatment.

4.1.3 Balancing the different human rights a person holds

A central issue in developing new legislation for New Zealand is how to balance the rights of an individual with the duty to protect the safety of an individual in a vulnerable and distressed state. Should the right to make autonomous decisions and the right to liberty (freedom) always be placed above the other rights a person holds? In some circumstances, a person's decision to refuse treatment may result in that person becoming more unwell, a loss of dignity or taking aggressive or suicidal actions. On the other hand, a person also has the right to make choices and decisions that others might consider unwise, including in relation to medical care or treatment.

In other health care settings, autonomy is respected through a person's right to give informed consent or refuse medical treatment. Informed consent is considered central to providing quality health care because decisions about medical treatment affect a person's life and wellbeing – sometimes greatly. In Aotearoa New Zealand, people's right to give informed consent, or refusal, to medical treatment is protected in our Bill of Rights (section 9) and in the Code of Rights, right 7.

4.1.4 Balancing a person's rights with the rights of others

Another important issue to think about is whether there are times when family, whānau or public concerns are strong enough to overrule a person's right to make their own choices.

When thinking about how to balance the rights of an individual with the rights of others, it is important to note there are other laws that allow intervention in a person's life without their consent, even if they retain their ability to make decisions for themselves. For example, the Crimes Act 1961 (section 41) allows the use of force that is 'reasonably necessary' to prevent a suicide or an offence that is likely to cause immediate or serious injury to a person or property. Common (judge-made) law also allows a person to be given medical treatment in an emergency.

4.1.5 Important Te Tiriti o Waitangi and cultural considerations

There are different cultural perspectives on the importance of individual autonomy. The concept of individual autonomy is grounded in Western thinking and is central to mainstream discussions about individual human rights and health ethics. However, individual autonomy is not given the same emphasis in all cultures.

Māori place a high value on the collective values and relationships within whānau, hāpu and iwi and the interwoven relationship between whānau, hāpu and iwi and the hauora (or wellbeing) of an individual whānau member (Elder 2019). Dr Hinemoa Elder writes that:

the concept of capacity ... for Māori is not best understood as residing in the individual alone, rather as contained within a collective. The individual draws support and strength from the presence of kaumātua and other generations and the connections amongst whānau, both living and dead. The preference is for decisions to be made collectively, following discussion (Elder 2019).

Aotearoa New Zealand is a highly diverse society, where other ethnic groups and cultures also place a high value on collective interests and relationships within the extended family and community, including Pacific cultures. In Pacific world views, a strong emphasis is placed on reciprocity and collectivism.

Being forced to operate in a way that is in opposition to one's own way of being (that is, collectivism versus individualism) creates mental distress, both for tangata whai ora and for other community and whānau members. Accommodating different world views within the new legislation should therefore contribute, along with other changes, to reducing current inequities that exist under the current Mental Health Act.

4.1.6 What a recovery approach to care should do

The current Mental Health Act has been criticised for not supporting a 'recovery approach' to mental health. A 'recovery approach' is a process of change through which individuals improve their health and wellbeing, live a self-directed life and strive to reach their full potential. The recovery approach is premised on strengths and what people can do and achieve rather than deficits and what they cannot achieve.

Truly recognising this approach therefore requires significant shifts in policy and practice. A recovery approach is best advanced when people can achieve sufficient wellness to participate in their communities with a maximum level of independence in both the presence and absence of symptoms of mental illness. Under this approach, people should 'have their mana protected and enhanced, experience respect, engage in shared decision-making and receive support to achieve their health and wellbeing goals' (Te Pou o te Whakaaro Nui 2018). As discussed in **Part 8.2: Respecting families and whānau**, whānau also play an important role as part of a person's recovery and support to become and stay well.

4.2 What we have heard

Many people and organisations have criticised compulsory mental health treatment, both in Aotearoa New Zealand and overseas, as failing to uphold people's human rights, including the rights to autonomy and freedom. Others have commented that

such treatment is an important part of ensuring that the right to good health and health services for people in a vulnerable and distressed state is upheld.

In earlier consultations, a number of people described their experience of being under the current Mental Health Act as disempowering and harmful (Government Inquiry into Mental Health and Addiction 2018a, Ministry of Health 2017a).

... creat[ing] a sense of shame and powerlessness that you can't manage your mental illness and medication independently ...

Person with lived experience perspective (Ministry of Health 2017a)

However, we have also heard from people who credit receiving compulsory treatment under the current Mental Health Act as lifesaving.

Anecdotally, we have heard some people may be placed under the current Mental Health Act as a way of getting access to treatment because of a lack of timely and appropriate alternative service options in the community (Ministry of Health 2017a). In addition, we have heard that some people request to stay under the current Mental Health Act to enable continued access to necessary medication at no cost, out of concern that the cost of the medication following release from compulsory treatment will negatively affect their ability to maintain their treatment and stay well.

We have also heard that some people may stay under the current Mental Health Act longer than is appropriate due to a 'culture of risk aversion and defensive practice' amongst clinicians and services (Government Inquiry into Mental Health and Addiction 2018a) as discussed in **section 1.3.3** above. This may result in a person being kept under the current Mental Health Act out of concern for what might happen to them (concern for the person's safety) or what the person might do (concern for the safety of others) if they are not under the current Mental Health Act, rather than being under the current Mental Health Act to promote the best wellbeing and mental health outcomes for the person. These are inappropriate reasons for a person to be placed or kept under compulsory treatment.

We need to set up protections both for tāngata whai ora and their responsible clinicians so that informed, dual responsibility for risk can [be] managed thoughtfully in a trusting space.

Consumer/family/whānau; NGO; service provider perspective
(Ministry of Health 2017a)

4.3 What we want to know from you now

4.3.1 What new legislation could do

Defining the overall purpose for the new legislation will be critical to guiding the rest of the decisions about the legislation and what it does or does not do. New legislation

could determine whether compulsory mental health treatment can ever be used and, if so, in what situations and how. This requires us to consider how legislation should balance the different rights an individual holds, as well as how to balance the rights of an individual with the rights of others.

If the legislation says that compulsory treatment can never be used, we may want to include requirements to ensure people are not pressured to accept mental health treatment they may not want through other ways and to ensure the rights of individuals in a state of vulnerability are recognised and protected.

If the legislation says that compulsory treatment can be used, then it must clearly describe when it can be used. This is discussed in more detail in **Part 5: Capacity and decision-making** below.

If compulsory assessment or treatment is allowed, the legislation must also clearly say where compulsory treatment can occur (for example in a hospital only or in both hospital and community settings) and what types of health professionals are allowed to assess whether a person needs compulsory mental health treatment and define phrases such as 'mental disorder'.

4.3.2 Questions for you

- What should be the purpose of mental health legislation?
- If new legislation does not allow compulsory mental health treatment, what requirements should be in legislation to protect an individual's rights and prevent an individual being coerced into accepting mental health treatment that they might not want?
 - What effect might new legislation that does not allow compulsory mental health treatment have for particular population groups (for example, children, disabled people, etc)?
 - How might new legislation that does not allow compulsory mental health treatment reflect te ao Māori?
- If legislation allows compulsory mental health treatment:
 - When should compulsory mental health treatment be allowed?
 - How should 'mental disorder' be defined, or do you think another phrase and definition should be used, and if so, what?
 - Where should compulsory mental health treatment be allowed to occur (for example, in hospitals and/or community settings and/or other facilities)?
 - How might new legislation that allows compulsory mental health treatment reflect te ao Māori?
 - What effect might new legislation that allows compulsory mental health treatment have for particular population groups (for example, children, disabled people, etc.)?
 - Which health professionals should be allowed to assess whether a person needs compulsory mental health treatment?

Part 5: Capacity and decision-making

5.1 What this part is about

If you believe that there are times when compulsory treatment should be allowed, this part will ask you for more detail about when you think it should be allowed. In this part, we will focus on a person's decision-making capacity (the ability to make choices for oneself) as a key part of deciding whether compulsory treatment should be allowed. This is because all other examples of legislation in other countries that allow compulsory mental health treatment only allow it if the person does not have capacity to make a decision about their treatment.

This part relates to Te Tiriti principles of:

- tino rangatiratanga
- active protection

and the Government principle as set out in the *Mental Health Act Reform* Cabinet Paper (Clark 2019) of:

- encouraging maximum independence, inclusion in society and the safety of individuals, their whānau and the community.

5.1.1 What the current legislation does or does not do

The current Mental Health Act allows for a person's decision about mental health treatment (usually a decision not to accept treatment) to be overruled even if that person is considered to have the ability to make that decision for themselves.

Another central requirement for the use of compulsory treatment under the current Mental Health Act is an assessment of the risk of 'serious danger' to the health and safety of self or others. A person can be placed under the current Mental Health Act if it is assessed that their 'abnormal state of mind' 'seriously diminishes' their ability to take care of themselves. The assessment is a judgement made by those who administer the current Mental Health Act based on many considerations and the unique circumstances of each case.

5.2 What you might want to know

5.2.1 A capacity-based approach

In Aotearoa New Zealand, the presumption that a person has decision-making capacity unless there are reasonable grounds to believe otherwise is already well established in law – including in the Code of Rights, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and the Protection of Personal and Property Rights Act 1988. There are also protections in place to help people to make decisions and to communicate their preferences (also known as supported decision-making), see **Part 6: Supporting people to make decisions**.

Even in the presence of a severe mental health condition, a person may retain capacity in relation to a range of decisions, including about their treatment, although this capacity may come and go at different times.

The Code of Rights acknowledges that, in some situations, a person may lack the capacity to make an informed choice or give informed consent. Sometimes, there will be another person who is legally authorised to give consent on their behalf, such as a welfare guardian or a person holding enduring power of attorney for personal care and welfare. However, if there is no such person, treatment can be provided if:

- it is in the best interests of the person
- reasonable steps have been taken to ascertain the person's views
- the health practitioner either has reasonable grounds to believe the treatment is consistent with the person's views or has consulted with others who have an interest in the person's welfare.

The Code of Rights also permits treatment in the absence of informed consent in an emergency or life-saving situation, where an intervention cannot wait.

Right 7(3) of the Code of Rights states that where a person has diminished competence (capacity) that person retains the right to make informed choices and give informed consent to the extent appropriate to that person's level of competence. This implies that a person should be supported as far as possible to make the decision for themselves.

In a health context, a health practitioner may make a 'capacity assessment' of a person's decision-making process. Under this approach, the person is entitled to make decisions that others might not agree with. The higher the risk of a decision, the more important it is that the person has decision-making capacity. A person is generally understood to have the capacity to give informed consent to a decision if they:

- understand the information given to them about the decision
- can remember the information
- can use or weigh up the information (including being able to rationally assess potential benefits and risks)
- can communicate their choice.

Given that a person may have capacity one day but not the next, it is essential that assessment of a person's capacity is made as close as possible to when the decision needs to be made and that mental health services are always mindful that capacity may be regained.

Difficulties can arise when a person has both a mental illness and another disability, such as a learning or physical disability. The mental health needs of people with additional disabilities must be treated following the same principles as people who do not have additional disabilities, and it should not be assumed that they lack capacity.

Some legislation adopts a 'general capacity standard'. An example is one used in the Mental Capacity Act 2005 of the United Kingdom, which has been copied in Aotearoa New Zealand's Substance Addiction (Compulsory Assessment and Treatment) Act 2017. This focuses on a person's ability to understand, use, recall and weigh relevant information; to foresee consequences; and to communicate a decision.

5.2.2 Cultural considerations

While most overseas jurisdictions have legislation that includes a capacity test, it is not sufficient for Aotearoa New Zealand to simply adopt a capacity test without first considering the specific context and cultural factors relevant to Aotearoa New Zealand.

In particular, it is critical we consider how the idea of a capacity test aligns with te ao Māori. Some Māori mental health clinicians have emphasised that 'greater inclusion of capacity principles ... requires careful consideration because of their potential impact on the balance between the rights of the individual and the collective rights within whānau and the wider community' (Elder and Tapsell 2013). For example, Māori may take a more collective approach to interpreting the will and preferences of someone who may be in need of compulsory mental health treatment.

The family group conference model

An alternative model for making decisions in the best interest of an individual in a vulnerable state who may have limited and/or fluctuating decision-making capacity and that explicitly recognises the key role of family, whānau and culture that already exists in the Aotearoa New Zealand context is the family group conference model (Oranga Tamariki Act 1989, sections 18, 18A, 20, 22 and 28).

The family group conference concept was created in the 1980s in Aotearoa New Zealand as a way to address concerns that the existing ways that the State intervened in family matters was oppressive and disempowering, especially for Māori and Pacific families and whānau, where decision-making is traditionally collective. It was intended to give families, whānau and children more of a voice in the process and was inspired by indigenous decision-making principles.

There is some critique about the way the family group conference model operates in practice. However, there may be lessons learnt from the model that could be applied in the mental health context, including whether a similar model might be appropriate.

5.2.3 The implications of a capacity-based approach

Adopting incapacity to consent to mental health treatment as a test for subjecting a person to compulsory detention and treatment would have important consequences that must be considered.

A person would have to lack the capacity to make an informed decision about mental health treatment to be placed under mental health legislation in the first place. In addition, there could be an argument that people would need to be released from the legislation once they regained their capacity. As a result, fewer people might be kept under compulsory treatment orders if they regained their capacity to make decisions during treatment and were then released from a compulsory treatment order.

Some people considered a serious risk to themselves or others might not be able to be placed (or kept) under mental health legislation if they kept the capacity to make decisions about treatment. Instead, other legal regimes might then be applied to them, including, in some cases, criminal law if a criminal offense has been committed.

5.2.4 The use of 'risk' as additional criteria for compulsory assessment and treatment

A number of countries and states that have updated their mental health legislation recently have required criteria beyond decision-making capacity to be met in order to initiate compulsory assessment and treatment. This aims to further limit the circumstances in which a person can be treated or detained without their consent.

These jurisdictions' mental health laws, including a number of Australian states, now include a range of other criteria that must be met in addition to the absence of decision-making capacity, such as serious risks to the safety of the person or others and the lack of a less restrictive alternative to compulsory assessment and treatment. Some countries also include criteria relating to a person's need for care and treatment to ensure they do not suffer further mental or physical deterioration.

There is more information about approaches to compulsory treatment in other countries in **Appendix B**.

Risk to self

The current Mental Health Act allows compulsory treatment when someone poses a 'serious danger' to themselves or when their ability to care for themselves is 'seriously diminished'. Most international legislation since the 2000s involves a test based on the need for treatment to address such risks (see **Appendix B**).

Part 4.1.3: Balancing the different human rights a person holds and **Part 4.1.4: Balancing a person's rights with the rights of others** look at some of the rights that need to be balanced when thinking about whether and how legislation should be used to promote the safety of someone with a serious mental health condition. For example, if treatment could only be given to people who lack the capacity (ability) to consent to that treatment, then there may be limited options to intervene if someone with the capacity to do so refuses treatment.

The new legislation gives us the opportunity to re-think the circumstances in which compulsory treatment could be used to intervene when someone is at risk of harm and what criteria should be used to determine this.

Risk to others

The current Mental Health Act includes criteria relating to whether the person poses a 'serious danger' to themselves or others. However, in practice, the scope of the interpretation of serious danger seems to have expanded over time with those who administer the Act taking an increasingly risk averse and predictive approach in applying the legal standard of serious danger (Dawson and Gledhill 2013).

Concerns with a 'predictive approach' to assessing risk

A predictive approach to assessing a person's risk is problematic as the evidence shows that risk assessment in psychiatry has major limitations, and there is great difficulty in predicting the outcomes of treatment in psychiatry (Large et al 2011).

For most people with severe mental illness, 'violence is no more predictable in them than in those without mental illness, nor is the propensity [tendency] for violence clearly more "treatable" in them' (Szmukler 2019). In the absence of alcohol, substance use or an antisocial personality, the risk is only slightly raised (Large et al 2011; Szmukler and Bach 2015; Varshney et al 2015). This compounds the issue of risk assessment and the linkage with mental disorder. When assessing people's mental health needs, forensic mental health services have introduced the use of structured professional judgement tools to enhance assessments. The assessment process results in a clear risk statement and risk management interventions, rather than a simplistic view of risk.

This evidence is important in the discussion around compulsory treatment because of the significant restrictions on a person's rights (to autonomy and liberty) that can result from an assessment of their perceived or predicted risk of harm. The evidence is also important because of the stigma and discrimination that people experience from the association of mental disorder with dangerousness. From a human rights perspective, it is important that the difficulty of predicting risk is accepted and appropriate consideration given to the use of less restrictive alternatives than detention (Gledhill 2013).

The issue then is whether detaining and/or treating a person without their consent based on the person's perceived or predicted risk to others is fair and reasonable and in what circumstances. This is particularly important in the context of the difficulty of predicting the risk to others, and the significant consequences for the individual.

5.3 What we have heard

We have heard calls for the legislation to give greater recognition to capacity and the right to consent (Ministry of Health 2017a). The current Mental Health Act has been criticised for allowing treatment to be imposed on a person even when they have the capacity (ability) to decide for themselves. This is at odds with overseas mental health laws described in **Appendix B** and with other laws of Aotearoa New Zealand.

As described in **Part 4.2: What we have heard** above, we have heard that some people find the experience of being under the current Mental Health Act to be disempowering, while others acknowledge it was necessary for their own safety and lives.

Concerns have also been raised that the risk criteria in the current Mental Health Act and the culture of risk-aversion described in *He Ara Oranga* (Government Inquiry into Mental Health and Addiction 2018a) have created a stigma that people who need compulsory mental health treatment are inherently dangerous. This stigma can lead to people not accessing care early for fear of what might happen to them or what others might think of them.

[they] give a sense of hopelessness that you are under state care and that you are legally restricted by the label 'mental patient' and feel marginalised and isolated by that status and what it implies ... [they] can feel more like punishment than treatment, especially as the focus is on the compulsory medication rather than rehabilitation.

Individual consumer perspective (Ministry of Health 2017a)

The MH Act makes me nervous of appointments with MH staff. I now don't trust them and wouldn't call them if I needed support.

Individual consumer perspective (Ministry of Health 2017a)

5.4 What we want to know from you now

5.4.1 What new legislation could do

If compulsory treatment were allowed, the legislation must clearly say under what circumstances that treatment would be allowed. The legislation could say whether a person must lack the capacity to make a decision about treatment and could state any other requirements that must be met before compulsory treatment would be allowed.

The legislation would also need to clearly say when compulsory treatment must stop. For example, the legislation could say that compulsory treatment must stop when a person regains capacity to make a decision about their own treatment.

Given the stigma and discrimination that can be experienced by people subject to compulsory treatment, it is crucial that any rules about when compulsory treatment can be used, or must stop, are clear to all who are subject to the rules, or use them, so that there is less scope for different interpretations.

5.4.2 Questions for you

- What criteria should the legislation use to say when compulsory mental health treatment is allowed?
- If decision-making capacity is a criterion, what matters should be relevant to an assessment of whether a person has the capacity for the purposes of mental health legislation?
- Who should assess whether a person has the capacity to make a decision about mental health treatment?
- If additional criteria for when compulsory assessment and treatment can be used are related to risk, how should these criteria be framed?
- How would the criteria for compulsory mental health treatment reflect te ao Māori?
- How should the legislation address cultural considerations in the requirements for when compulsory mental health treatment can be used?
- How would the criteria for compulsory mental health treatment affect particular population groups (for example, children, disabled people, etc)?

Part 6: Supporting people to make decisions

6.1 What this part is about

This part deals with what requirements should be included in the legislation to make sure people are supported to make their own decisions about mental health treatment.

Even if you believe the legislation should never allow compulsory treatment, this part is important because people will still need support to make their own treatment decisions at times.

This part relates to Te Tiriti principles of:

- tino rangatiratanga
- partnership
- options

and the Government principles as set out in the *Mental Health Act Reform* Cabinet Paper (Clark 2019) of:

- taking a human rights approach
- taking a recovery approach to care and treatment
- providing timely service access and choice
- encouraging maximum independence, inclusion in society and the safety of individuals, their whānau and the community.

6.1.1 What the current legislation does or does not do

The current Mental Health Act does not have any requirements for people to be supported in making a decision about their own mental health treatment, but it also does not say that people and health practitioners cannot use supported decision-making tools. **Guidance** has been given to practitioners about how to use supported decision-making to help people receiving compulsory treatment have more say in the treatment they receive (Ministry of Health 2020a).

Overall, the current Mental Health Act relies on the use of substituted decision-making, which is when someone makes a decision for another person – which may not be the decision the person would have made for themselves.

Aotearoa New Zealand law, the Code of Rights, which also applies to individuals under the current Mental Health Act, acknowledges a person's right to use a particular supported decision-making tool called an advance directive (see above). But uptake of advance directives among people with experience of severe mental illness has been limited (Lenagh-Glue et al 2018).

The Code of Rights also states that people have the right to make informed choices and give informed consent to the extent appropriate for their level of competence, and it recognises a person's right to have support to do so if needed (right 7(3) and right 8 of the Code of Rights).

6.2 What you might want to know

6.2.1 What is supported decision-making

Supported decision-making means providing a person with the help they need to allow them to make decisions about their own treatment, care or support. Support is a broad term that covers both informal and formal support arrangements, of varying types and intensity. For example, people may call on one or more trusted support people to help them make decisions.

Supported decision-making recognises that all people have will and preferences and that steps must be taken to find out the will and preferences of people as much as possible, even when this takes considerable effort (Mirfin-Veitch 2016).

Supported decision-making also acknowledges that decision-making capacity is not something people simply have or don't have. People may have a certain degree of capacity, but this capacity may change at different times and in relation to different issues. For this reason, it is important that any new legislation recognises this ability for change and offers a range of supports to help people make their own decisions.

Supported decision-making differs from substituted decision-making, in which specific individuals, such as guardians, are granted responsibility to make decisions for those considered to be unable to make decisions themselves. It also differs from shared decision-making, which describes person-centred approaches in health care settings where people and their treating team make decisions together about treatment (Simmons and Gooding 2017).

6.2.2 Supported decision-making and human rights

Article 12 of the CRPD (equal recognition before the law) clearly states that disabled people, including those with mental illness, have the right to control decisions about their lives with whatever kinds of support they need and that countries must establish the arrangements to make this possible. This includes the right to give consent for medical treatment.

Article 12 also makes clear that countries, including Aotearoa New Zealand, should have safeguards in place for people who need another person to present their will and preferences when a decision needs to be made to ensure the person is protected. Generally, these requirements under Article 12 are referred to as supported decision-making.

While most countries that are signatories to the CRPD continue to authorise some form of substituted decision-making (particularly as a last resort for people experiencing severe mental illness who have lost capacity), many are seeking to improve the quality of mental health services and ensure that supported decision-making systems are in place (Knight et al 2018).

6.2.3 Types of supported decision-making tools

Outlined below are some of the key tools used to help with supported decision-making by people with severe mental illness. These tools may be suitable for inclusion in new legislation. It is important to note that family, whānau and friends are part of a person's natural supports when it comes to decision-making.

Advance directives

An advance directive is a statement, usually in writing, made by a person to say what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or some other reason. The statement can reflect either specific directions about care and treatment or it can describe the process a person wants followed to support their decision-making, such as specifying who should be involved. Support for advance planning is explicitly encouraged as an important form of support by the Disabilities Committee. In Aotearoa New Zealand all consumers have the right to use advance directives under right 7(5) of the Code of Rights.

There is some evidence that appropriate use of advance directives in mental health care leads to positive treatment outcomes, such as improved relationships between people and their treating team (de Jong et al 2016) and reduced use of compulsory treatment (de Jong et al 2016; Molyneaux et al 2018).

Two studies in Aotearoa New Zealand have shown strong support for the general idea of advance directives among clinicians and consumers in Aotearoa New Zealand (Thom et al 2015; Lenagh-Glue et al 2018). However, the second study found that clinicians and consumers had different expectations as to how far advance directives should be followed in practice, particularly when a person experiencing severe mental distress refuses treatment. These different expectations need to be carefully considered when implementing advance directives (Lenagh-Glue et al 2018).

Nominated people

Broadly, the role of a nominated person is to assist a person who is unwell to exercise their rights. The nominated person can help represent the unwell person's intentions and preferences about their treatment and recovery to members of the treating team.

A nominated person does not necessarily have to be a person with any specific experience or training. For example, in Victoria, Australia, any person who is willing, available and able to fulfil the obligations can be a nominated person as long as they have the capacity at the time a decision has to be made (Department of Health and Human Services nd).

The role is activated when it is confirmed that the person who the nominated person will represent lacks capacity to make the relevant decisions. The nominated person has no independent power to refuse treatment on a person's behalf.

There are also some obligations on the person in charge of the care facility to ask that person if they have a nominated person and, if they do, to ensure the nominated person is listed on the person's medical record and to check the currency from time to time. Generally, the nominated person is protected from civil (non-criminal) liability for anything they have done honestly or without recklessness.

Independent advocates

In mental health, an independent advocate is a person separate from mental health services who specialises in supporting people to understand their rights and participates in decisions about the care and treatment of the person they are advocating for.

Independent advocates should be free from conflicts of interest, including association with mental health service providers or funders. They support people to gain access to information, to explore their rights and to understand their options. They speak on behalf of people who are unable to speak for themselves or choose not to do so.

Some evidence suggests that independent advocates are well suited to roles intended to support decision-making because they do not come to the supporter role with assumptions about the person and they do not have a personal stake in the choices a person might have (Burgin 2016).

Some countries have independent advocacy built in to their policy and legislation. For example, Scottish mental health legislation requires local authorities (councils) to provide information to their Mental Welfare Commission about how they are meeting their duties under the Mental Health (Care and Treatment) (Scotland) Act 2003 to provide independent advocacy services, at least every two years.

6.2.4 Examples of supported decision-making in legislation

A number of other countries (including Scotland, Northern Ireland, India, four Australian states, some provinces of Canada and some states of the United States) recognise advance directives in their mental health, or mental capacity, legislation and require clinicians to have regard for them. Some exceptions to a request for treatment (for example, where the treatment is not available or is inappropriate in the circumstances) are usually provided.

Most overseas mental health legislation still permits a refusal of psychiatric treatment, expressed in an advance directive, to be overridden in certain circumstances. Some legislation requires that the treating team tell a person that they are entitled to make an advance directive.

Some countries such as Scotland, Northern Ireland and a number of Australian states also allow a person to choose a 'nominated person', if they want one, to help represent their will and preferences if they lose decision-making capacity.

Swedish law provides for the appointment of a legal mentor or personal ombudsman (PO), with the cost covered by the state, to assist people to make legal decisions. The POs are usually social workers or lawyers who must be able to effectively argue for their clients' rights in front of various authorities or courts. The United Nations Office of the High Commissioner for Human Rights has identified this scheme as an effective legal mechanism for providing supported decision-making to people with psychosocial disability, also known as mental illness or distress (Gooding and Flynn 2015).

6.3 What we have heard

We have heard that people need to be at the centre of any decisions made about their care. Supported decision-making gives people greater autonomy over their lives which is fundamental to a person's wellbeing.

Submitters to the Inquiry into Mental Health and Addiction said that they want people who use services to be more in control of the decisions made around their care and treatment and planning.

Not just one thing works, and every person is different, we need to learn to adapt to the needs of the patient on a case-by-case basis. The patient needs to make the decisions of their own personal recovery ... ongoing support is needed.

(service user)

(Government Inquiry into Mental Health and Addiction 2018b)

Submitters also indicated that families and whānau should be more involved in planning and decision-making.

6.4 What we want to know from you now

6.4.1 What new legislation could do

Legislation could require people to be supported to make decisions about their care and treatment and require health practitioners to follow these decisions. Similarly, legislation could say if there are ever circumstances where health practitioners might override a decision made through a supported decision-making process.

Legislation could also clearly enable the use of specific supported decision-making processes or tools.

6.4.2 Questions for you

- What should be the role of supported decision-making in mental health legislation?
- How might a supported decision-making process reflect te ao Māori?
- What supported decision-making tools or processes, if any, should the legislation enable people to use?
- When, if ever, should the legislation allow a decision made through a supported decision-making process to be overridden?
- What effect would supported decision-making have for particular population groups (for example, children, disabled people, etc)?

Part 7: Seclusion, restraint and other restrictive practices

7.1 What this part is about

This part will ask you about whether new legislation should ever allow the use of seclusion, restraint or other restrictive practices and, if so, what requirements should be in place to ensure people's rights are protected and use is appropriately limited.

This part relates to Te Tiriti principles of:

- active protection
- options
- equity

and to the Government principles as set out in the *Mental Health Act Reform Cabinet Paper* (Clark 2019) of:

- taking a human rights approach
- improving equity of care and treatment
- taking a recovery approach to care and treatment
- providing the least restrictive mental health care options.

7.1.1 What the current legislation does or does not do

The current Mental Health Act allows for people under the Act to be secluded when necessary for their care or for the protection of other people. 'Being secluded' means being placed alone in a room or area from which you cannot freely exit. Seclusion can only occur where, and for as long as, it is necessary for the care or treatment of the person or for the protection of other people. Only people who are subject to an inpatient compulsory order can be secluded and only with the authority of the person's responsible clinician (except in an emergency).

Seclusion can only take place in rooms designated by the Directors of Area Mental Health Services (DAMHS), and clinicians must record the time period and circumstances of each episode of seclusion in a register that must be available for district inspectors to review.

The current Mental Health Act does not explicitly allow for the use of restraint. 'Restraint' means direct physical contact with an intention of preventing, restricting or subduing a person's movements. However the Act does permit the use of force when exercising other powers under the Act, which implies that, in some cases, restraint may reasonably be used.

The use of seclusion and restraint by health and disability services (including mental health services) is guided by the requirements of the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008) (the Standards) (Standards New Zealand 2008).¹⁰

The Standards require that the use of restraint be minimised. They also say that services must be guided by ethical principles, including acting for the person's benefit, avoiding harm to the person or others and respecting the dignity of the person and the person's human rights.

The current Mental Health Act includes the power for a medical practitioner to give a person sedative medication when there are reasonable grounds for believing that the person presents a significant danger to themselves or others and that it is in the interests of the person to receive a sedative drug urgently. This power was added to the current Mental Health Act following the Innes case (*Innes v Wong* [1996] 3 NZLR 238 (HC)). It permits a person to be sedated before transportation to hospital for assessment (which can involve travelling long distances, in some parts of the country) when this is considered the most safe and humane option.

7.2 What you might want to know

In 2019, 10.4 percent of people in adult mental health services were secluded at some stage during the reporting period (Ministry of Health 2021). The rates of seclusion varied widely across DHBs. As noted in **Part 1.3.2: Evidence of inequities under the Act**, Māori are much more likely to be secluded than non-Māori.

The Ministry has committed to the goal of reducing and eventually eliminating seclusion (Ministry of Health 2019). Ministry guidelines say that seclusion should be an uncommon event and that services should use it only when there is an imminent risk of danger to the individual or others and no other safe and effective alternative is possible. The guidelines also identify best practice methods for using seclusion in mental health inpatient units (Ministry of Health 2010).

In recent years, many other countries have also increasingly moved to reduce or eliminate the use of seclusion and restraint in recognition of human rights and ethical concerns. However, many countries still use these practices (Steinert et al 2010).

¹⁰ Standards NZ has recently released revised restraint minimisation standards. The revised standards will come into effect on 28 February 2022.

There are also a number of national and local DHB initiatives under way to reduce the use of seclusion and restraint in mental health services. While improvements have been made in some regions, overall, such initiatives have yet to significantly improve the inequitable outcomes experienced by Māori who come under the current Mental Health Act.

'Zero seclusion: safety and dignity for all' (Zero seclusion), a project run by the Health Quality and Safety Commission, is being undertaken in partnership with Te Pou (the national mental health, addiction and disability centre) and DHBs. The Zero seclusion project is currently working across the country to implement evidence-based strategies to reduce and eliminate the use of seclusion and is monitoring for unintended consequences, such as increases in the use of sedative medications or restraint.

7.3 What we have heard

Aotearoa New Zealand has been criticised for the ongoing use and high rates of seclusion and restraint in our mental health services, both by the United Nations Committees for the CRPD (UN Disability Committee 2014) and the Convention Against Torture & Other Cruel, Inhuman and Degrading Treatment (UN Committee Against Torture 2015), and by local monitoring organisations such as the New Zealand Human Rights Commission (2020) and the Ombudsman (2020), which, along with the Disabled People's Organisations Coalition (DPO Coalition), form the Independent Monitoring Mechanism (IMM).¹¹ The IMM has also called for the repeal and replacement of the current Mental Health Act and the elimination of seclusion and restraint (IMMCRPD 2020).

Recent New Zealand research has also shown that seclusion and restraint can damage relationships and traumatise both the person and health workers involved (Te Pou o te Whakaaro Nui 2018).

Many people spoke to the Government Inquiry into Mental Health and Addiction about seclusion and restraint. *He Ara Oranga* summarised these voices and expressed that:

- seclusion and restraint are overused, especially for Māori
- many seclusion rooms are in a poor state
- the use of seclusion and restraint contributes to peoples' reluctance to seek help
- many people see seclusion as a breach of human rights, which contributes to peoples' experience of harm and powerlessness
- law reform should minimise the use of compulsion and seclusion in inpatient units (Government Inquiry into Mental Health and Addiction 2018a).

¹¹ The IMM works to promote, protect and monitor implementation of the CRPD in Aotearoa New Zealand with the aim of helping to make disability rights real.

We have also heard concerns that if new legislation prohibits the use of seclusion and restraint, staff and patient safety may be compromised. Further, there are concerns that eliminating or severely limiting the use of seclusion or restraint could result in increased usage of sedating medication.

7.4 What we want to know from you now

7.4.1 What new legislation could do

Legislation can say whether or not seclusion, or the use of restraint or other restrictive practices, are ever allowed. If these practices are allowed, the legislation can clearly say when they are allowed and can have requirements and limitations to ensure the use is minimised and people are protected as much as possible.

While changing the legislation to help reduce the use of restraint and seclusion in mental health services will be key, we also know further work will be required to support the changes, especially in upskilling the workforce and improving mental health facilities.

7.4.2 Questions for you

- What, if any, restrictive practices should the legislation allow?
- How should legislation ensure the use or prohibition of restrictive practices reflects te ao Māori?
- If any restrictive practices are allowed, what rules should be in the legislation about their use?
- What rules should legislation include to ensure patients and staff are safe whether or not restrictive practices are allowed?
- What effect would allowing or prohibiting restrictive practices have for particular population groups (for example, children, disabled people, etc)?

Part 8: Addressing specific population group needs

8.1 What this part is about

This part recognises that there are certain population groups that will need special consideration under any new mental health legislation. These include people with different cultural backgrounds; disabled people; families, whānau, āiga and carers; children and young people; and people within the justice system.

This part will ask you questions about how new legislation should address the specific needs of these population groups. Each section under this part addresses a particular population group.

This part relates to Te Tiriti principles of:

- tino rangatiratanga
- active protection
- equity

and the Government principles as set out in the *Mental Health Act Reform* Cabinet Paper (Clark 2019) of:

- improving equity of care and treatment
- taking a recovery approach to care and treatment
- respecting family and whānau.

8.2 Addressing cultural needs

8.2.1 What current legislation does or does not do

Sections 5(2) and 65 of the current Mental Health Act require that all powers and proceedings under the Act must be carried out with proper recognition of the importance and significance to the person and their ties with their family, whānau, hāpu, iwi and family group and with proper respect for the person's cultural and ethnic identity, language and religious or ethical beliefs.

However, the current Mental Health Act does not have clear requirements around how practitioners must give proper respect for cultural and ethnic identity. For example, there are no requirements under the current Mental Health Act for a person to receive a cultural needs assessment when the compulsory assessment or treatment process is started.

8.2.2 What you might want to know

As noted above, the current Mental Health Act recognises the importance of people's cultural and ethnic identities and makes high-level statements that those identities must be respected. However, given the significant ethnic and cultural disparities in the population groups most affected by the Act and the fact that there is often a difference between the cultures of the people giving and receiving treatment, the provisions in the current Mental Health Act may not be enough.

Guidelines to the current Mental Health Act emphasise the need to provide culturally appropriate care and treatment, including specific suggestions for how such care can be delivered, however, these do not have the same force of law as legislation.

8.2.3 What we have heard

We have heard that the current Mental Health Act does not do enough to ensure cultural needs are met. The current provisions in the legislation do not provide enough clear direction for practitioners to know what they need to be doing, and there are not enough clear requirements in the legislation.

The Mental Health Act is a blunt tool/instrument which drives a dominant Pākehā worldview. Specific Pacific worldviews are not considered within the Mental Health Act. Cultural significance and meaning held by patient's/service users and their families are not given credence.

(Government Inquiry into Mental Health and Addiction nd)

8.2.4 What we want to know from you now

What new legislation could do

New legislation could include very specific and detailed requirements, such as requirements for specific cultural models of care to be used, or the legislation could have general requirements similar to the current approach. The legislation could also take a middle ground, with some specific requirements combined with other high-level requirements to guide practices.

Questions for you

- What is needed in legislation to ensure people receive culturally appropriate care?
- How would addressing culturally appropriate care in the legislation reflect te ao Māori?
- How might addressing culturally appropriate care in the legislation affect particular population groups (for example, children, disabled people, etc)?

8.3 Respecting families and whānau

8.3.1 What current legislation does or does not do

The current Mental Health Act (section 7A) states that consultation with whānau should be sought during the compulsory assessment and treatment process. The purpose of this consultation is to strengthen family and whānau involvement in the person's treatment and care. However, health practitioners have discretion in the way they implement sections 5(2), 65 and 7A of the Act and, in reality, consultation with whānau does not occur in a consistent manner across DHBs (see Ministry of Health 2019 and 2021 for more information).

8.3.2 What you might want to know

When considering how new legislation can better respect family and whānau, it is necessary to understand what comprises family and whānau. Definitions and understandings of family, whānau and āiga vary and are informed by different cultural backgrounds and practices. The CRPD recognises the family is the natural and fundamental group unit of society and has an important role in supporting people with disabilities, including mental health needs.¹² Almost always, the most important perspective for defining family and whānau is that of the patient or proposed patient.

The importance of family, whānau and personal relationships in a person's illness, diagnosis, treatment and recovery is widely acknowledged, as is the potential effect of a person receiving compulsory care on their family and whānau. One of the key roles of family, whānau and āiga members is also that of being a carer, providing care and support for friends, family, whānau and āiga members with a disability, health condition, illness or injury who need help with everyday living.

Any new mental health law must therefore consider how to best facilitate culturally appropriate inclusion of family, whānau, āiga and carers.

¹² Preamble clause 24 of the CRPD.

Finding the right balance between the wishes of the individual and those of their family, whānau, āiga and carers can be difficult, and becomes especially difficult where there are circumstances, lifestyles or relationships that may be harmful to the person receiving care under the Act, especially when the person lacks the capacity to make their own decisions. This is referenced in **section 5.2.2 above**.

8.3.3 What we have heard

The Government Inquiry into Mental Health and Addiction heard from submitters that:

Whānau involvement is critical for successfully addressing mental health and addiction challenges: whānau should be co-participants in services, involved in decision-making and assisted to provide the support expected of families

(Government Inquiry into Mental Health and Addiction 2018a)

When families and whānau are included in meetings with clinicians it makes a difference – families know what is happening for their family member and are given opportunities to ‘fill in the gaps’; so the clinician has the full picture of what is happening at home for the consumer and can make better informed decisions about subsequent treatment.

(NGO-collated responses from family and whānau)

(Government Inquiry into Mental Health and Addiction 2018a)

The Ministry has also been told that family and whānau do not have enough of a say in their family member’s care and treatment.

Not only was he in crisis, but our family was also in crisis ... When he is coming home to us and we all live under the same roof, we need to know what’s going on! So we can support him. We don’t need to know everything, just the main things such as medication, who are the main people we can contact should we have concerns ... Take our family concerns seriously.

Family/whānau perspective (Ministry of Health 2017a)

However, this conflicts with feedback from some people with lived experience, who have said they feel that family and whānau have too much influence. Involving family can also challenge the information sharing requirements under the Privacy Act 2020 and Health Information Privacy Code 2020.

8.3.4 What we want to know from you now

What new legislation could do

Legislation could include clear requirements telling health practitioners when family and whānau must be included in the care and treatment process, how this should be done, when it is acceptable to not include family and whānau and what information must or must not be shared with family and whānau.

Questions for you

- How, if ever, should legislation require the involvement of family and whānau, where appropriate?
- How would any requirements for family and whānau involvement reflect te ao Māori?
- What rights and responsibilities should family and whānau be given in the legislation?
- When is it appropriate not to require the involvement of family and whānau?
- What information, if any, should legislation require to be shared with family and whānau?

8.4 Children and young people

8.4.1 What current legislation does or does not do

The current Mental Health Act applies to all people irrespective of age. However, while children and young people have all the same rights and protections as adults under the Act, they also have some additional protections. These include that:

- the consent of a parent or guardian for any assessment or treatment is not sufficient consent for the purposes of the Act
- wherever practicable, the first examination of a child or young person under the age of 17 years should be carried out by a psychiatrist with expertise in child psychiatry
- when a child or young person's condition is reviewed by the Mental Health Review Tribunal, the tribunal should include at least one member specialising in child psychiatry
- the responsible clinician must review a young person's case no later than one month before their 17th birthday if they are still under a compulsory treatment order.

The current Mental Health Act also permits a child or young person's principal caregiver to be present throughout any hearing (unless the judge orders otherwise) and this caregiver may be heard by the Court. The current Mental Health Act also requires that a child or young person's principal caregiver must be informed and consulted on assessment and treatment decisions for the child or young person.

Under the current Mental Health Act, young people aged 16 years and over can be involved in making decisions around their treatment but, like adults under the Act, this can be overridden if the responsible clinician and a second psychiatrist agree that treatment is in the young person's best interests. In children and young people under the age of 16 years, the Act transfers what is normally a parental right to make decisions for their child to the state.

8.4.2 What you might want to know

Our international human rights obligations, including the CRPD and the United Nations Convention on the Rights of the Child (CRC) require any new mental health law that considers human rights or decision-making capacity to include special considerations for children and young people (see **Appendix C**).

Any new law must also consider Aotearoa New Zealand's Care of Children Act 2004, which gives a young person who is 16 years or over the right to give or refuse consent to medical treatment, without the need for parental involvement.

In 2020, there were 433 children and young people aged 17 years or younger under the current Mental Health Act. Of these, 191 were Māori (44 percent).¹³

Under common (judge-made) law, children under the age of 16 years may give valid and effective consent if they have sufficient understanding of the significance of the proposed treatment. This is known as the 'Gillick competency test' and is applied in situations of general health care and treatment in Aotearoa New Zealand. The Gillick competency test recognises that children and young people develop at different rates and will therefore develop decision-making capacity at different ages. When a child is not 'Gillick competent', the law generally favours a parent's right to decide for that child. This is reinforced in the Code of Rights where the relevant question is whether the level of understanding of a particular child allows them to consent to a particular service or treatment (Ministry of Health 1998).

The Care of Children Act 2004, CRC and the CRPD all emphasise the importance of the views of the child, irrespective of the child's Gillick competency. Under the CRC and the CRPD, children are entitled to receive information in a format that is appropriate for them and to receive the support they need to be able to express their views.

The role of family, whānau, hāpu and iwi must also be a central consideration when we are thinking about how new legislation might apply to children and young people. A major theme from national engagement on Tamariki Tū, Tamariki Ora: New Zealand's First Child and Youth Wellbeing Strategy was that we must put families and whānau at the centre of solutions to improve child and youth wellbeing (Department of the Prime Minister and Cabinet 2019).

8.4.3 What we have heard

The current Mental Health Act applies to all ages, but we have little information directly from children and young people about how they feel about their experiences under it. This is a gap that we intend to fill as part of this work to repeal and replace the current Mental Health Act. However, we do know that there is clinical and public disapproval of the fact that children as young as 9 years old have been experiencing seclusion. Addressing this is considered above in **Part 7: Seclusion, restraint and other restrictive practices**.

¹³ Source: Programme for the Integration of Mental Health Data (PRIMHD). Extracted: 28 May 2021.

8.4.4 What we want to know from you now

What new legislation could do

If compulsory mental health treatment is allowed, new legislation could say whether compulsory mental health treatment should ever be allowed for children and young people, and the legislation could clearly say up to what age a person is considered a child or young people. New legislation could also include requirements to enable a child or young people to make decisions about their care or treatment if they have the capacity to make such a decision.

New legislation should also clarify what must be done when mental health clinicians and parents, whānau or caregivers do not agree with each other about consent or treatment issues. Such disagreements have the potential to affect the wellbeing or recovery of the child or young person, so legislation could say that specialist child and adolescent expertise is mandatory in these circumstances.

Questions for you

- How should compulsory treatment be applied to children and young people?
- How would mental health legislation specific to children and young people reflect te ao Māori?
- How should legislation require family and whānau be involved in situations that relate to children and young people?
- What should the process be when staff and family and whānau disagree on treatment for children or young people?
- What should supported decision-making look like for children and young people?

8.5 Disabled people

8.5.1 What current legislation does or does not do

The current Mental Health Act states that a person cannot be subjected to the compulsory assessment and treatment process solely because they have an intellectual disability. However, it is possible for a person to have an intellectual disability and a mental health condition, in which case, if the person has a mental disorder, as defined by the current Mental Health Act, then compulsory assessment and treatment may be used.

The current Mental Health Act requires provision of interpreters if:

- the first or preferred language of the person is a language other than English, including te reo Māori and New Zealand Sign Language
- the person is unable, because of physical disability, to understand English.

Aside from these provisions, the current Mental Health Act does not include any additional requirements or protections with respect to people with disabilities who are placed under the Act.

8.5.2 What you might want to know

The disabled population of Aotearoa New Zealand is diverse. In general, disabled people have poorer health outcomes than non-disabled people and, while they are often high users of mainstream health services, they do not experience the same outcomes as their non-disabled peers. Tāngata whaikaha and whānau whaikaha (Māori disabled people and their whānau), Pacific disabled people and their āiga and people with an intellectual/learning disability experience worse outcomes than any other group of disabled people. Moreover, disabled people often have other health conditions that affect their quality of life.

The provision of accessible services, including information provided in alternate formats (for example, Braille, large print, Easy Read, New Zealand Sign Language) will enable disabled people to access services in a similar manner to their non-disabled peers.

8.5.3 What we have heard

We have heard that the current Mental Health Act does not sufficiently acknowledge the specific needs of disabled people and does not provide adequate protections to ensure these needs are met when compulsory assessment and treatment are used. We have heard, in particular, that the needs of the deaf community are not being met.

8.5.4 What we want to know from you now

What new legislation could do

Legislation could explicitly identify groups of people, such as disabled people, and include specific requirements and/or protections to ensure particular needs of that group are met. Legislation could also require specific reporting and monitoring to ensure particular needs of a group are being met.

Questions for you

- What, if any, specific requirements should legislation include regarding disabled people?
- How would any specific legislative requirements regarding disabled people reflect te ao Māori?

8.6 People within the justice system (special patients)

8.6.1 What current legislation does or does not do

The Criminal Procedure (Mentally Impaired Persons) Act 2003 allows Courts to find people being charged with a crime either not guilty by reason of insanity or unfit to stand trial. In either of these instances, the people then become special patients and receive mental health treatment in a secure environment.

The current Mental Health Act identifies clear processes for these special patients to progress through their recovery, including giving them gradually longer periods of leave from the mental health service until they are ready to live in the community and no longer require special patient status. This progression often takes many years.

People who have been found unfit to stand trial may be referred back to the Court once they have regained fitness. They may then be released, convicted and sentenced, or found not guilty by reason of insanity and once again made a special patient.

People in prison who meet the criteria may receive compulsory care under the current Mental Health Act. As the current Mental Health Act does not permit compulsory treatment to be provided within a prison facility, which is not a considered a therapeutic environment, these people are transferred to mental health services in order to receive treatment as special patients. When they have recovered, they are then returned to prison. Many people with mental illness can be treated with their consent in prison.

8.6.2 What you may want to know

During 2019, there were 403 people with special patient status. Māori in particular are significantly overrepresented in the forensic mental health system. In 2019, nearly 50 percent (48.9 percent) of special patients were Māori (Ministry of Health 2021).

Special rules may be needed for special patients if capacity, or lack of capacity, to consent to mental health treatment is to be a general requirement for placement under mental health legislation. Such rules may be needed to prevent the early discharge of special patients who continue to pose a serious threat of harm to themselves or others.

Special patients do not lose their essential human rights. While a person's behaviour may provide a legitimate reason for limiting that person's right to freedom, it does not necessarily provide a legitimate reason to limit their other rights, such as the right to give consent to treatment. If it is decided that capacity to give informed consent is an appropriate criterion, it would be difficult to justify applying a different test to people in the justice system.

Research in Aotearoa New Zealand estimates that approximately 66 percent of individuals who receive care as special patients have the capacity to make decisions about their care and treatment. Of these individuals assessed as having decision-making capacity, less than 3 percent indicated they would refuse treatment if given the opportunity (Skipworth et al 2013).

This research suggests that a framework that allows the will and preferences of an individual who is in the court or prison system to be considered should not cause significant concern that it might lead to large numbers of individuals refusing treatment when they might benefit from treatment. The research also did not find evidence that enabling these individuals to exercise their decision-making capacity poses a concern for the safety of others (Skipworth et al 2013). However, the concerns remain about how to address length of care and treatment.

Special patients are currently released only if they accept treatment and both their mental disorder and their risk of reoffending resolves or becomes minimal so that compulsory treatment is no longer needed. If the new legislation only allows compulsory treatment when a person lacks decision-making capacity, conditions for release from special patient status will need to be redefined.

Potentially the most complicated situation to consider and address is that of a person found not guilty by reason of insanity. Currently, someone found not guilty by reason of insanity does not receive any specified length of detention. Instead, the person is made a special patient under the current Mental Health Act with no defined length of time attached to their order. It is important to consider what changes might be needed for new legislation and what changes might be needed to the Criminal Procedure (Mentally Impaired Persons) Act 2003 to adequately balance a person's rights against concerns about safety.

8.6.3 What we have heard

The voice of people with lived experience as a special patient has not been well represented in previous consultations, so unfortunately, we have not heard much from this population. However, in 2010, the New Zealand Law Commission undertook a review entitled *Mental Impairment Decision-Making and the Insanity Defence*, which included several recommendations related to potential process reforms for special patients, including that decisions about special patient leave or change of status applications should not be made by Ministers as is currently the case. These recommendations will be considered as part of the development of a new legislation.

8.6.4 What we want to know from you now

What new legislation could do

New legislation could say whether compulsory mental health treatment should be allowed for people in the justice system and if so under what circumstances. The legislation could also say if a person in the justice system who has decision-making capacity could still be required to undergo compulsory mental health treatment even if they would choose not to.

Questions for you

- How should the legislation treat a person with decision-making capacity in the justice system who does not want to receive mental health treatment?
- How would legislative requirements relating to people in the justice system reflect te ao Māori?
- How should compulsory mental health treatment be applied for a person found not guilty by reason of insanity?
- Would legislative requirements relating to people in the justice system affect particular population groups (for example, children, disabled people, etc), and if so, how?

Part 9: Protecting and monitoring people's rights

9.1 What this part is about

If new legislation continues to allow for compulsory mental health legislation, it must also provide people with appropriate protections, including access to justice. This includes fair and transparent legal processes, regular reviews of compulsory treatment orders and the ability for individuals to effectively challenge compulsory treatment orders.

This part describes some of the protections and monitoring mechanisms built into the current Mental Health Act and asks you questions about what changes might be needed to strengthen and improve the protection of people's rights.

This part relates to Te Tiriti principle of:

- active protection

and the Government principles as set out in the *Mental Health Act Reform* Cabinet Paper (Clark 2019) of:

- improving equity of care and treatment
- providing the least restrictive mental health care options.

9.2 Court, tribunal and other legal processes

9.2.1 What current legislation does or does not do

At present, the task of conducting review hearings for people placed under the current Mental Health Act is spread between the District Court and the Mental Health Review Tribunal (the tribunal). The current Mental Health Act specifies that applications for compulsory treatment orders and their extensions should be heard and determined specifically by a Family Court judge unless it is not practicable, in which case any other District Court judge can be responsible.

Following the initial periods of compulsory assessment, the Family Court judge is responsible for deciding whether the person should be placed under a compulsory treatment order.

While under a compulsory treatment order, the person must be clinically reviewed by their responsible clinician three months after the beginning of the order and then at least once every six months. If the clinical review finds that the person should remain under the Act, the person may apply to the tribunal to review their condition.

The tribunal is created under the Mental Health Act and reviews some compulsory treatment orders on a patient's request, as well as resolving certain complaints. Each sitting tribunal is made up of at least one psychiatrist, one lawyer and a community member. If a person disagrees with the tribunal's decision that they should remain under the Act, they may appeal to the District Court.

9.2.2 What you may want to know

Using the District Court or tribunal to approve compulsory treatment

A major advantage of using the Family Court division of the District Court is that it operates throughout the country. Family Court judges are able to conduct hearings, usually at short notice, and some judges specialise in this work. However, the Family Court division of the District Court is under increasing pressure with growing caseloads. This is making it more difficult to ensure hearings under the current Mental Health Act occur in a timely manner.

Further, as noted below in **Part 9.2.3: What we have heard**, there are concerns that judges rely too heavily on the clinical advice provided in a hearing. As well, the formal court hearing process can be difficult for people to understand and navigate and can create unnecessary stress.

Tribunal processes are less formal than the court's, which can benefit people who may feel uncomfortable or nervous dealing with the court process. Having all Mental Health Act compulsory treatment order processes handled by a tribunal could work well in that the tribunal is focused on working with people with mental health needs, and it does not have to balance workload with non-mental health hearings. This approach would also free up the Family Court's time and resources to refocus on other non-mental health matters.

However, if all processes were conducted by the tribunal, many more people would need to be appointed to the tribunal to ensure there were enough capacity for the tribunal to handle all applications and hearings. If the tribunal continued to include a psychiatrist, many more psychiatrists would have to be recruited to ensure the panel always has a psychiatrist available, drawing them away from clinical work. Recruiting sufficient psychiatrists to serve on tribunals has proved difficult in other countries.

The difficulties may lead to the use of tribunals that have only a senior lawyer and consumer representative and/or take place via videoconferencing rather than face-to-face hearings outside the main centres.

Reviewing and challenging legal decisions

The legal criteria for discharge from the current Mental Health Act has also been criticised on the grounds that the Act makes it harder for a person to be released from the Act than it does for a person to be placed under the Act.

The criteria for discharge from the current Mental Health Act were established in the *Waitemata Health v A-G [2001] NZFLR 1122* case, which specifically considered the interpretation of the concept 'fit to be released from compulsory status'. In that case, the Court of Appeal held that the phrase means that a patient must be no longer mentally disordered and thereby can be deemed to be fit to be released.

The result of this decision is that the exit criterion of being fit to be released (no longer mentally disordered) is not the same as the entrance criteria (mentally disordered *and* necessary to undergo compulsory assessment and treatment).

The Court's consideration of 'whether or not, having regard to all the circumstances of the case, it is necessary to make a compulsory treatment order' is an additional protection for a person being considered for compulsory treatment that is not available to people who are seeking to be released from the current Mental Health Act.

To simplify what this means, if a person still meets the definition of 'mentally disordered' but compulsory treatment is no longer needed, the person will not meet the Court's definition of the phrase 'fit to be released from compulsory status'.

9.2.3 What we have heard

Some people have said that their experience of the District Court and the tribunal was confusing and disempowering, while others have said that the legal nature of these hearings creates an 'us and them' environment, which is unhelpful when trying to support people to improve their mental wellbeing. Other people have suggested that support from an independent advocate, or a peer worker, could help improve this experience (Ministry of Health 2017).

There is also a sense that the legal system should be more supportive of people who are placed under the current Mental Health Act. Concerns have been raised about:

- the general quality of legal representation, in terms of a lack of understanding about mental health issues and the current Mental Health Act
- the perception that judges rely too heavily on clinical advice and do not take advice or information from other sources, such as the family and whānau, kaumatua or kuia, sufficiently into account.

Concern has also been raised that processes under the Act do not adequately support people to challenge their compulsory status and that this might be contributing to the low rate of decisions to release someone from compulsory status. Following its visit to Aotearoa New Zealand in early 2014, the United Nations Working Group on Arbitrary Detention expressed concern that, in practice, compulsory treatment orders are largely clinical decisions and difficult to challenge effectively (UN Working Group on Arbitrary Detention 2015).

There are also concerns about the lack of cultural support for people experiencing Court proceedings under the Act, especially given the overrepresentation of Māori and Pacific peoples under the current Mental Health Act. This issue is discussed separately above in **Part 8.2: Addressing cultural needs**.

9.2.4 What we want to know from you

What new legislation could do

If compulsory mental health treatment were allowed, new legislation could say who has the power to approve the use of compulsory mental health treatment. The legislation could say that only a judge in a court can approve, or it could create a full-time tribunal and require all applications and processes related to the use of compulsory treatment to be considered by the tribunal, or it could create a completely different process with a different decision-maker who is neither a court judge nor tribunal panel.

The legislation would need to clearly describe the process that must be followed for compulsory treatment to be approved. For example, the legislation would describe how many days the decision-maker has to consider and approve or deny an application for compulsory treatment; what information must be provided to the decision-maker and where a hearing can or must take place (for example, legislation could specify that hearings can take place on marae or through the use of audiovisual link technology). Legislation should also clearly describe the process for a person to challenge a decision.

Questions for you

- Who should be responsible for approving the use of compulsory mental health treatment?
- What should be the process for approving the use of compulsory mental health treatment?
- What information should be required for requests to approve the use of compulsory mental health treatment?
- How would the process for approving compulsory mental health treatment reflect te ao Māori?

- What supports could be made available to make it easier for people to engage with the process for approving the use of compulsory mental health treatment?
- What would be the effect for particular population groups (for example, children, disabled people, etc) of having either the District Court or a tribunal responsible for approving the use of compulsory mental health treatment?

9.3 Challenging clinical decisions

9.3.1 What current legislation does or does not do

Under the current Mental Health Act, a person is required to accept treatment as directed by their responsible clinician during the first month of compulsory treatment. After this month, people may only receive treatment when they have given written consent. However, if a patient refuses to give their consent, this can be overridden if their responsible clinician and a second psychiatrist (a second opinion) agree that the treatment is in the person's interest.

9.3.2 What you may want to know

A study that reviewed the use of second opinions in three DHBs across Aotearoa New Zealand noted that when responsible clinicians and the second psychiatrists are unable to resolve disagreements about treatment decisions, there is no resolution process in the current Mental Health Act nor any guidance that makes sure that a clinically sound, transparent and nationally consistent process is used (Dawson et al 2013). Currently, a different psychiatrist may be asked to provide a new second opinion, which may effectively allow the responsible clinician to bypass the first second opinion provided.

9.3.3 What we have heard

People have expressed a number of criticisms about the current consent and 'second opinion' process, including that:

- the idea of providing consent to treatment is often difficult to understand given that the person is already under a compulsory treatment order
- the ability of the mental health service to override the person's wishes means that refusing to give consent is often little more than a symbolic protest
- psychiatrists providing second opinions are not always perceived to be independent from the responsible clinician.

We have also heard that people are not given adequate information about all available treatment options and are not offered an opportunity to make a choice about the treatment option they wish to use.

9.3.4 What we want to know from you

What new legislation could do

If compulsory mental health treatment were allowed, new legislation could include a clear process for what a person can do when they do not agree with the treatment chosen by a practitioner.

Questions for you

- What should the process be when a person disagrees with the compulsory mental health treatment chosen for them by a health practitioner?
- Under what circumstances should a health practitioner be able to override a person's decision about a particular treatment if the person is under compulsory treatment?

9.4 The role of police

9.4.1 What the current legislation does or does not do

The current Mental Health Act enables police assistance for the purpose of detaining a person:

- in a public place, if the police have a reasonable belief that the person meets the definition of mentally disordered under the Act
- at a private place if a medical practitioner or duly authorised officer requests assistance.

The current Mental Health Act enables police to detain a person for up to six hours while arrangements are made for an examination of the person under the Act. Police detain people in emergency departments, as well as police cells, which is the least preferred option.

9.4.2 What you may want to know

Despite increased resources for primary mental health and specialist crisis services, there is an ongoing demand for police to respond to individuals in mental health crisis in the community. Some police districts in Aotearoa New Zealand have developed policies to seek alternative and more appropriate places of safety than police cells for detaining a person who is waiting for an examination, such as an emergency department.

Other jurisdictions have moved the role of pick-up and detention while awaiting examination to other parts of the emergency response system, for example New South Wales in Australia has moved this role to the ambulance service.

9.4.3 What we have heard

We have heard concerns that involving police in the pick-up and detention of people in need of mental health assistance further promotes stigma and criminalisation of people with mental health needs.

9.4.4 What we want to know from you

What new legislation could do

Legislation could specify what role, if any, police have with respect to administering any part of the legislation.

Question for you

- What role, if any, should police have in the new legislation?

9.5 Monitoring individuals' rights

9.5.1 What the current legislation does or does not do

The current Mental Health Act includes several different roles responsible for overseeing the use of the Act and ensuring that people's rights under the Act are upheld. These include:

- **Directors of Area Mental Health Services:** These roles are generally responsible for oversight of the Mental Health Act at the service or facility level, including numerous specific requirements and duties as outlined throughout the current Mental Health Act. They must provide reports on the use of the Act and their powers under the Act to the Director of Mental Health and Addiction Services every three months.
- **District inspectors:** These are lawyers appointed under the current Mental Health Act to assist people who are being assessed or treated under the Act by providing information and support to make sure the patient's rights under Part 6 of the Act are being upheld. District inspectors also regularly visit mental health services to monitor the quality and safety of the service.

- Duly authorised officers: These are health professionals with appropriate mental health experience responsible for helping people in need of compulsory assessment and going through the compulsory assessment and treatment order process.
- Director of Mental Health and Addiction Services: This person is responsible for monitoring the use of the current Mental Health Act across Aotearoa New Zealand.

Beyond the ability to make a complaint to a district inspector, the current Mental Health Act does not include any other specific complaints processes.

9.5.2 What you may want to know

Directors of Area Mental Health Services and district inspectors regularly report to the Director of Mental Health and Addiction Services to enable effective monitoring of the use of the current Mental Health Act at a national level.

A person under the current Mental Health Act, their family or whānau, or another person concerned that people's rights under the current Mental Health Act are being violated, may make a complaint to a district inspector. After talking with the person, the district inspector may choose to investigate and report the matter to the mental health service, together with any recommendations the district inspector sees fit. If the person is unhappy with the results of the district inspector's investigation, they may refer their complaint to the Mental Health Review Tribunal.

The Director of Mental Health and Addiction Services can also initiate an inquiry into a mental health hospital service when serious or systemic issues are identified through regular reporting and/or complaints from individuals.

Aside from talking to a district inspector, people receiving compulsory assessment or treatment under the current Mental Health Act have a range of options for making formal complaints.

Complaining to the health service or district health board

People receiving compulsory assessment and treatment under the current Mental Health Act may make a complaint directly to the health service or DHB in the same manner as any other person who has received health or disability treatment. They may also request independent advocacy through the Nationwide Health and Disability Advocacy Service.¹⁴

¹⁴ The Nationwide Health and Disability Advocacy Service was established in 1996 as an independent organisation providing free advice about individuals' rights around health and disability services, including help in making complaints.

Complaining to the Health and Disability Commissioner

A person may make a complaint to the Health and Disability Commissioner (HDC) if they are dissatisfied with their care and treatment or with the response they have received to a complaint made directly to a service or DHB. The HDC is an independent watchdog that helps to provide health and disability services consumers with a voice, resolve complaints and hold health providers to account for meeting their obligations and duties under the Code of Rights. The HDC can refer complaints to district inspectors. District inspectors, or others can likewise refer complaints to the HDC.

Complaining about district inspectors

A person can make a complaint about a district inspector to the Director of Mental Health and Addiction Services, who is responsible for national oversight of the Mental Health Act. The Director of Mental Health and Addiction Services may then order an investigation and take a range of actions, including suspending or removing the district inspector from their role.

Complaining about police conduct

The current Mental Health Act allows mental health services to call police for assistance to help assess, restrain or seclude people who are highly distressed.

People who wish to complain about police conduct that occurred while police were supporting mental health services may do so through the Independent Police Conduct Authority (IPCA). The IPCA is an independent body responsible for considering all complaints about police.

9.5.3 What we have heard

The Ministry has been told that the role of the district inspector is not well understood by clinicians, tangata whai ora, people with lived experience and families and whānau. This may prevent people from approaching district inspectors for assistance. Some people think that district inspectors should have more powers to require change if they think it is needed.

The Ministry has also been told that the current process for complaints, which is spread across different organisations with no clear single process to follow is confusing and difficult for people to understand and navigate.

9.5.4 What we want to know from you now

What new legislation could do

New legislation could create specific roles with clear responsibilities to oversee and ensure people's rights are protected. This could include specific reporting requirements to ensure transparency. New legislation could also create a clear process for individuals who wish to make complaints about their care or treatment or the care and treatment of others.

Questions for you

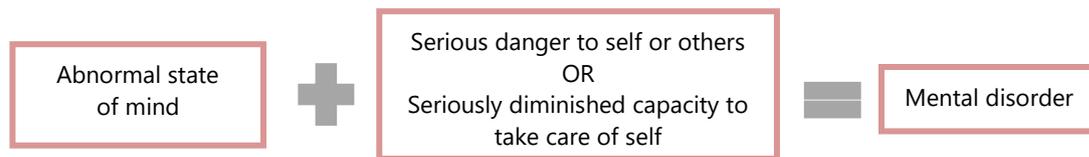
- What monitoring and oversight roles should be created in new legislation?
- What should be the powers and responsibilities of these roles?
- What should be the complaints process for compulsory mental health treatment?

Appendices

Appendix A: Overview of the current Mental Health Act

When the current Mental Health Act can be used

Under the current Mental Health Act, a person must meet the definition of mental disorder before they can be subject to compulsory assessment or treatment. The definition of mental disorder in the Act is defined by a two-part test depicted below.

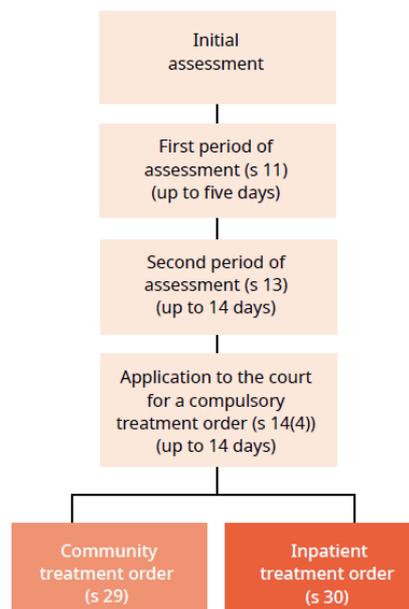


In this test, having an 'abnormal state of mind' means experiencing symptoms such as delusions, thought disorder or mood disorder. These symptoms must then be serious enough that they cause the person to pose a 'serious danger to self or others or seriously diminished capacity to take care of self'.

The Act also clearly specifies that a person cannot be detained only because of their religious, cultural or political beliefs or because of substance abuse, intellectual disability, sexual preferences or criminal or delinquent behaviour.

Process for compulsory assessment and treatment

Anyone over the age of 18 years who believes a person may be suffering from a mental disorder and has seen that person within three days of the application can apply to a Director of Area Mental Health Services to have that person assessed to see whether they do have a mental disorder under the current Mental Health Act. When a person is believed to meet the definition of mental disorder, a health practitioner will conduct an initial assessment. If the health practitioner is of the opinion that the person is not mentally disordered, they are free from further assessment and treatment.



If the health practitioner finds that the person is mentally disordered, an initial period of five days' compulsory assessment may begin, during which time the person must accept treatment. Following this, if still required, a further 14 days of additional assessment may be carried out.

After a person has undergone these two periods of compulsory assessment, an application may be made to the District Court to place the person under a six-month compulsory treatment order. Compulsory treatment orders may be made for inpatient care (in a hospital) or for community care (in the person's home or a supported living arrangement).

Protections for people under the current Mental Health Act

The current Mental Health Act includes a number of protections to ensure that it is used fairly and that people have a say in their treatment. However, some of these protections could be strengthened and improved.

Reviews and hearings

At any time during the compulsory assessment process, the person (or someone acting on their behalf) can request that a judge review their condition to determine whether they should continue to be assessed under the current Mental Health Act.

As noted above, following the initial periods of compulsory assessment, the District Court is responsible for deciding whether the person should be placed under a compulsory treatment order.

While under a compulsory treatment order, the person must be clinically reviewed by their responsible clinician three months after the beginning of the order and then at least once every six months. If the clinical review finds that the person should remain under the Act, the person may apply to the Mental Health Review Tribunal (MHRT) to further review their condition.

The 'second opinion' process

During the first month of a compulsory treatment order, people are required to accept treatment as directed by their responsible clinician. After this month, people may only receive treatment when they have given written consent or when their responsible clinician and a second psychiatrist agree that the treatment is in the person's interest.

District inspectors and peoples' rights under the current Mental Health Act

District inspectors are lawyers appointed to assist people who are being assessed or treated under the current Mental Health Act. District inspectors meet with people early into the compulsory assessment process to provide advice and notify them of their right to a review in the District Court.

People may also complain to a district inspector if they think that their rights under the current Mental Health Act have been denied or breached.

After talking with the person, the district inspector may choose to investigate and report the matter to the mental health service, together with any recommendations the district inspector sees fit. If the person is unhappy with the results of the district inspector's investigation, they may refer the complaint to the Mental Health Review Tribunal.

District inspectors also regularly visit mental health services to monitor the quality and safety of the service.

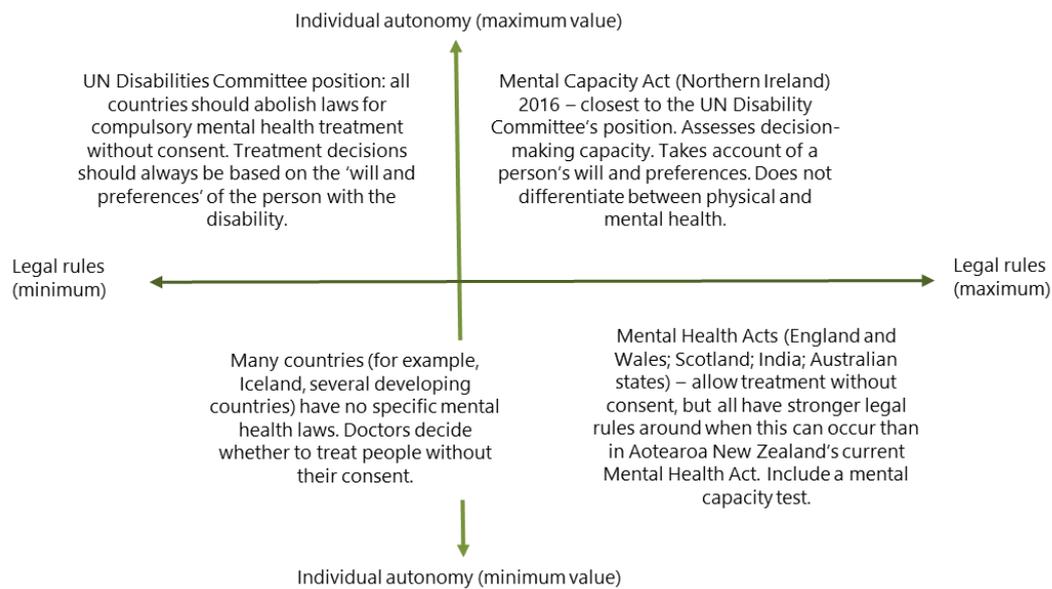
Making formal complaints

Aside from talking to a district inspector, people receiving compulsory assessment or treatment under the current Mental Health Act have a range of options for making formal complaints.

Appendix B: Approaches to compulsory treatment in other countries

Figure 1 below provides a comparison of the main approaches to mental health law used overseas.

Figure 1: Striking the balance in other countries



Source: Adapted from Figure 2, Owen et al 2018

Australia

All but one of Australia's eight states have undertaken a major review of their mental health laws since the country agreed to be bound by the CRPD. Six states have updated their legislation. All states include a presumption of decision-making capacity, and six include a decision-making capacity test in their legislation, in addition to other criteria for coming under the Act. For example, to be placed under Queensland's Mental Health Act 2016, in addition to meeting the tests of mental disorder and danger, it must be shown that 'the person does not have the capacity to consent to be treated for the illness' (section 12(1)(b)).

England and Wales

In 2017, the Government of the United Kingdom (UK Government) commissioned a review of their Mental Health Act 2007 (which applies only to England and Wales) in light of their rising rates of detention under the Act, the disproportionate number of people from Black and other minority communities detained under the Act and concerns that the law is out of step with a modern approach to mental health care. The most important themes emerging from this review and its recommendations were that patients must be supported to make more decisions for themselves and the law must support this (Department of Health and Social Care 2018).

In January 2021, the UK Government released a discussion document proposing a wide range of changes to 'rebalance' their Mental Health Act 2007. The proposed changes are based on four principles:

- choice and autonomy – ensuring service users' views and choices are respected
- least restriction – ensuring the Act's powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- the person as an individual – ensuring patients are viewed and treated as individuals.

Public consultation on the proposals closed in April 2021 (Department of Health and Social Care 2021).

India

The Indian Mental Healthcare Act, passed in 2017, seeks to comply with the CRPD. The Act includes a presumption of decision-making capacity and relies on a capacity test for both detention and treatment. It allows all adults to make advance directives and nominate representatives for shared decision-making. The Act also grants a legally-binding right to mental health care and broad social rights for the mentally ill, amongst other things. Resourcing of services and administration of the Act and an increasingly legalised approach to care, which may result in lengthy court processes, have been identified as potential challenges to the Act's implementation (Duffy and Kelly 2019).

Northern Ireland

Northern Ireland recently enacted the Mental Capacity Act (Northern Ireland) 2016. This new Act is a 'fusion law', which sets out when compulsory treatment can be given, using the same standards for people with either a mental or physical disorder. The Act presumes that a person has the mental capacity to make decisions unless it is proven otherwise following an assessment of their capacity. It allows people without capacity to be treated on a 'best interests' basis. The Act allows people to make an advance directive (a legal document in which a person specifies what actions should be taken

for their health if they are no longer able to make decisions for themselves) and to nominate people to be their representatives.

At this stage, Northern Ireland appears to be the country whose mental health law is most aligned to the CRPD. The Northern Ireland legislation is still coming into force through a phased implementation and transition, and therefore, we do not yet know the full effects of the new legislation.

Scotland

In 2019 Scotland announced a review of both its mental health legislation and its incapacity legislation, with the aim of strengthening the rights, protections and support for people with mental illness. In announcing the review, the Scottish Government said they are 'absolutely committed to bringing change to people's lives and ensuring that mental health is given parity with physical health' (Scottish Government 2019). The current Mental Health (Care and Treatment Act) 2003 requires an assessment of a person's decision-making capacity. The Act also gives people the right to access independent advocacy.

Appendix C: Human rights in Aotearoa New Zealand's laws and international agreements

New Zealand Bill of Rights Act

The New Zealand Bill of Rights Act 1990 (the Bill of Rights) protects and promotes human rights and fundamental freedoms in Aotearoa New Zealand. Some of the most relevant rights to this discussion are:

- the right to refuse to undergo medical treatment
- the right not to be arbitrarily (without good reason) arrested or detained (held)
- the right to see a lawyer without delay if you are being held
- the right to freedom of thought, conscience, religion and belief and to practise your religion, culture and language
- the right not to be subjected to torture or cruel treatment
- the right to freedom from discrimination, for example, based on disability, gender, sexual orientation, political opinions or religious beliefs
- the rights to freedom of expression, association and peaceful assembly
- the right to be secure against unreasonable search or seizure.

However, the rights set out in the Bill of Rights can be limited by other laws where this is 'demonstrably justified in a free and democratic society'. For example, the current Mental Health Act overrules a person's right to refuse medical treatment.

Code of Health and Disability Services Consumers' Rights

The Code of Health and Disability Services Consumers' Rights (the Code of Rights) establishes the rights of consumers and the obligations and duties of health care and disability service providers to comply with the Code of Rights. It is a regulation under the Health and Disability Commissioner Act 1994 and specifies the following rights.

- Right 1: The right to be treated with respect
- Right 2: The right to freedom from discrimination, coercion, harassment and exploitation
- Right 3: The right to dignity and independence
- Right 4: The right to services of an appropriate standard
- Right 5: The right to effective communication

- Right 6: The right to be fully informed
- Right 7: The right to make an informed choice and give informed consent
- Right 8: The right to support
- Right 9: Rights in respect of teaching or research
- Right 10: The right to complain.

International human rights

The four international agreements most relevant to discussions about compulsory mental health treatment in Aotearoa New Zealand are the United Nations:

- Convention on the Rights of Persons with Disabilities (CRPD)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Declaration on the Rights of Indigenous Peoples (UNDRIP)
- Convention on the Rights of the Child (UNCROC).

By signing these international agreements, the Government of New Zealand has committed to implementing their principles and instructions and to monitoring the outcomes.

Convention on the Rights of Persons with Disabilities

The CRPD aims to ensure that people with disabilities (including mental health conditions) are not discriminated against and enjoy the same rights and freedoms as people without disabilities. Since 2007, a total of 177 countries have ratified the CRPD, including New Zealand.

Under the convention, psychosocial disabilities, also known as mental illness, are considered to be a disability. Disability is not attributable to the individual but rather is viewed as resulting from barriers in the social, political and physical environments, which restrict people in exercising their human rights.

The central rights in the CRPD relevant to discussions about compulsory mental health treatment include:

- Article 3A: respect for inherent dignity and the freedom to make your own choices
- Article 12: equal recognition of disabled people before the law
- Article 14: the right to be free and safe and not deprived of freedom arbitrarily

- Article 17: protecting the integrity of the person and their right to respect for their physical and mental integrity on an equal basis with others
- Article 25: the right to enjoy the highest attainable standard of health and health services.

Deprivation of liberty on the basis of disability, including mental illness, is not compliant with the CRPD. Article 12 includes a person's right to proper support to make their own decisions and requires safeguards to be in place to protect a person when they need someone else to speak for them (see **Part 6: Supporting people to make decisions**).

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture) was passed by the United Nations General Assembly in 1984 and signed by New Zealand in 1989. New Zealand also signed the Optional Protocol to the Convention against Torture in 2007, which requires the government of New Zealand to make sure there is independent monitoring of places of detention (where people are held against their will) to ensure that such places are free of torture and other cruel or degrading treatment.

In New Zealand, the Ombudsman is responsible for monitoring mental health facilities for compliance with the Convention against Torture. The Ombudsman has identified instances where the Convention against Torture may be breached for some people under the current Mental Health Act. For example, there have been instances of people spending excessive lengths of time in seclusion or in compulsory care because of a shortage of suitable community-based accommodation.

The government of New Zealand must regularly report to the United Nations Subcommittee on Torture about measures it is taking to implement the Convention against Torture.

Declaration on the Rights of Indigenous Peoples

The UNDRIP makes explicit that the rights set out in other international human rights conventions applying to indigenous peoples. It sets out the individual and collective rights of indigenous peoples, including the right to identity and the right to health. It also prohibits discrimination against indigenous peoples, and 'promotes their full and effective participation in all matters that concern them and their right to remain distinct and to pursue their own visions of economic and social development'.

The UNDRIP was passed by the United Nations General Assembly in 2007 and endorsed by New Zealand in 2010. The New Zealand Human Rights Commission recommends that 'government decisions and policy should take the principles of UNDRIP into consideration alongside the Treaty [of Waitangi]' (New Zealand Human Rights Commission 2010).

Article 24 of the UNDRIP is particularly relevant to mental health legislation. Under Article 24(1), indigenous peoples (Māori) have 'the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals'. They also have 'the right to access, without any discrimination, to all social and health services'. Under Article 24(2) indigenous peoples (Māori) 'have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right'.

Convention of the Rights of the Child

The UNCROC sets out rights that specifically apply to children (up to the age of 18 years) in international law.

The UNCROC obligates the government to make sure that the best interests of the child are taken into account in policy decisions. It includes children's rights to protection from discrimination, to an opinion and for that opinion to be heard, and to be informed about and participate in achieving their rights and the right to life.

The UNCROC also includes special measures to protect those belonging to minority groups. In Aotearoa New Zealand, the UNCROC should be implemented in the context of Te Tiriti and should support the benefits of belonging to whānau, hāpu or iwi (Ministry of Social Development nd).

Glossary

Advance directive

A written statement or document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

Capacity

In a health context, a person's ability to make informed choices and give informed consent, or refusal, to a specific care or treatment decision at a particular time.

Code of Health and Disability Services Consumers' Rights (Code of Rights)

A regulation (set of rules) under the Health and Disability Commissioner Act 1994 that establishes the rights of people receiving health and disability services and sets out the obligations and duties of service providers in relation to those rights.

Community treatment order

A compulsory treatment order made under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the current Mental Health Act) for treatment in either the person's home or a designated location in the community.

Compulsory treatment order

An order made by a court, directing a person to receive compulsory treatment under the current Mental Health Act. Compulsory treatment orders may be made for treatment in community or inpatient settings.

Criminal Procedure (Mentally Impaired Persons) Act 2003

A law that provides the courts with appropriate options for detaining, assessing and caring for defendants and offenders with a 'mental impairment' (including a mental illness or intellectual disability).

Director of Area Mental Health Services (DAMHS)

A senior mental health professional appointed under the current Mental Health Act who is responsible for overseeing the use of the current Mental Health Act in their area.

District health boards (DHBs)

Organisations responsible for providing or funding the provision of health services in their district. As at 2021, there were 20 DHBs in Aotearoa New Zealand.

District inspector (DI)

Lawyers appointed under the current Mental Health Act to protect the rights of people receiving compulsory assessment or treatment.

Government Inquiry into Mental Health and Addiction

An inquiry established in January 2018 to identify unmet needs and develop recommendations for a better mental health and addiction system for Aotearoa New Zealand. The inquiry publicly released its final report, *He Ara Oranga*, in December 2018.

He Ara Oranga

The final report of the Government Inquiry into Mental Health and Addiction, released publicly in December 2018.

Health and Disability Commissioner (HDC)

A Crown entity responsible for promoting and protecting the rights of health and disability services consumers and facilitating the fair, simple, speedy and efficient resolution of health and disability complaints.

Health inequity

An inequality that we can attribute to social, cultural and/or economic factors rather than biomedical ones.

Health Quality and Safety Commission (HQSC)

A Crown entity that works with clinicians, providers and consumers to improve health and disability support services.

Indefinite treatment order

A compulsory treatment order that has been extended after two six-month periods and is no longer subject to regular judicial review.

Independent advocate

People who work independently of any mental health services to support people who are receiving compulsory assessment or treatment under the current Mental Health Act.

Inpatient compulsory treatment order

A compulsory treatment order made under the current Mental Health Act for treatment in a hospital inpatient setting.

Mental disorder

A person's state defined as the person having an 'abnormal state of mind' to such a degree that the person poses a serious danger to themselves or others or has a seriously diminished capacity to take care of themselves. In order to receive compulsory assessment or treatment under the current Mental Health Act, a person must meet the definition of 'mental disorder'.

Mental Health (Compulsory Assessment and Treatment) Act 1992 (the current Mental Health Act)

A law that allows people to receive compulsory mental health assessment and treatment.

Mental Health Review Tribunal

An independent tribunal created under the current Mental Health Act to review compulsory treatment orders and resolve certain complaints. Each sitting tribunal comprises a psychiatrist, a lawyer and a community member.

New Zealand Bill of Rights Act 1990 (NZBORA)

A law that sets out peoples' rights and fundamental freedoms.

Nominated person

In some countries, mental health legislation enables a person to choose a 'nominated person' to help represent their will and preferences if they lose decision-making capacity.

Office of the Director of Mental Health and Addiction Services

A team in the Ministry of Health, led by the Director of Mental Health and Addiction, responsible for overseeing the use of the current Mental Health Act in Aotearoa New Zealand.

Official Information Act 1982

A New Zealand Act that gives the public the right to access official information held by government bodies. This promotes openness and transparency in our government organisations and enables greater public participation in our country's governance.

Person with lived experience

A person who experiences or has experienced mental illness and who uses or has used mental health services. The person may have received treatment under the current Mental Health Act.

Protection of Personal and Property Rights Act 1988 (PPPR Act)

A law that provides mechanisms for the management of property (including vehicles) of adults who do not have the capacity to manage their own affairs or take care of themselves.

Recovery approach to mental distress and mental illness

The fundamental paradigm in Aotearoa New Zealand mental health policy and practice. From a service user's perspective, it has been described as 'achieving the life we want in the presence or absence of mental distress'. From a policy and service provider's perspective, it means that policy and service providers must operate their services in ways that assist recovery for service users. A recovery approach focuses on hope, self-determination, active citizenship and a holistic range of services

Responsible clinician

The clinician who is in charge of a person's treatment under the current Mental Health Act.

Restraint

Direct physical contact with an intention of preventing, restricting or subduing a person's movements.

Seclusion

Placing a person alone in a room or area from which they cannot freely exit.

Second opinion

A responsible clinician may provide treatment to people under the current Mental Health Act without their consent, as long as a second psychiatrist provides a 'second opinion' that agrees that the treatment the person is receiving is in that person's best interest.

Special patient

A person receiving compulsory treatment under the current Mental Health Act who has entered through the Justice and/or Corrections systems.

Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SACAT Act)

A law that allows people to receive compulsory assessment and treatment for severe substance addiction.

Supported decision-making

The process of providing a person with the help they need to make decisions about their treatment, care or support.

Tangata whai ora

People with experience of mental illness, who are seeking wellness or recovery of self. Literally translated as 'people seeking wellness'.

United Nations Committee on the Rights of Persons with Disabilities (the Disabilities Committee)

A body of experts that meets two times a year to consider reports from countries about their compliance with the United Nations Convention on the Rights of Persons with Disabilities.

United Nations Convention on the Rights of Persons with Disabilities (CRPD)

An international human rights treaty ratified by New Zealand in September 2008 that is intended to protect the rights and dignity of people with disabilities. Parties to the CRPD are required to promote, protect and ensure the full enjoyment of human rights by people with disabilities and ensure that such people enjoy full equality under the law.

United Nations Convention on the Rights of the Child (UNCROC)

An international human rights treaty ratified by New Zealand in 1993 that sets out the civil, political, economic, social, health and cultural rights of children.

United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

An international declaration that defines the individual and collective rights of indigenous peoples, including their ownership rights to cultural and ceremonial expression, identity, language, employment, health, education and other issues.

Wai 2575 / the Waitangi Tribunal's Health Services and Outcomes Kaupapa Inquiry

An inquiry run by the Waitangi Tribunal that aims to hear all claims concerning Māori grievances relating to health services and outcomes of national significance for Māori.

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