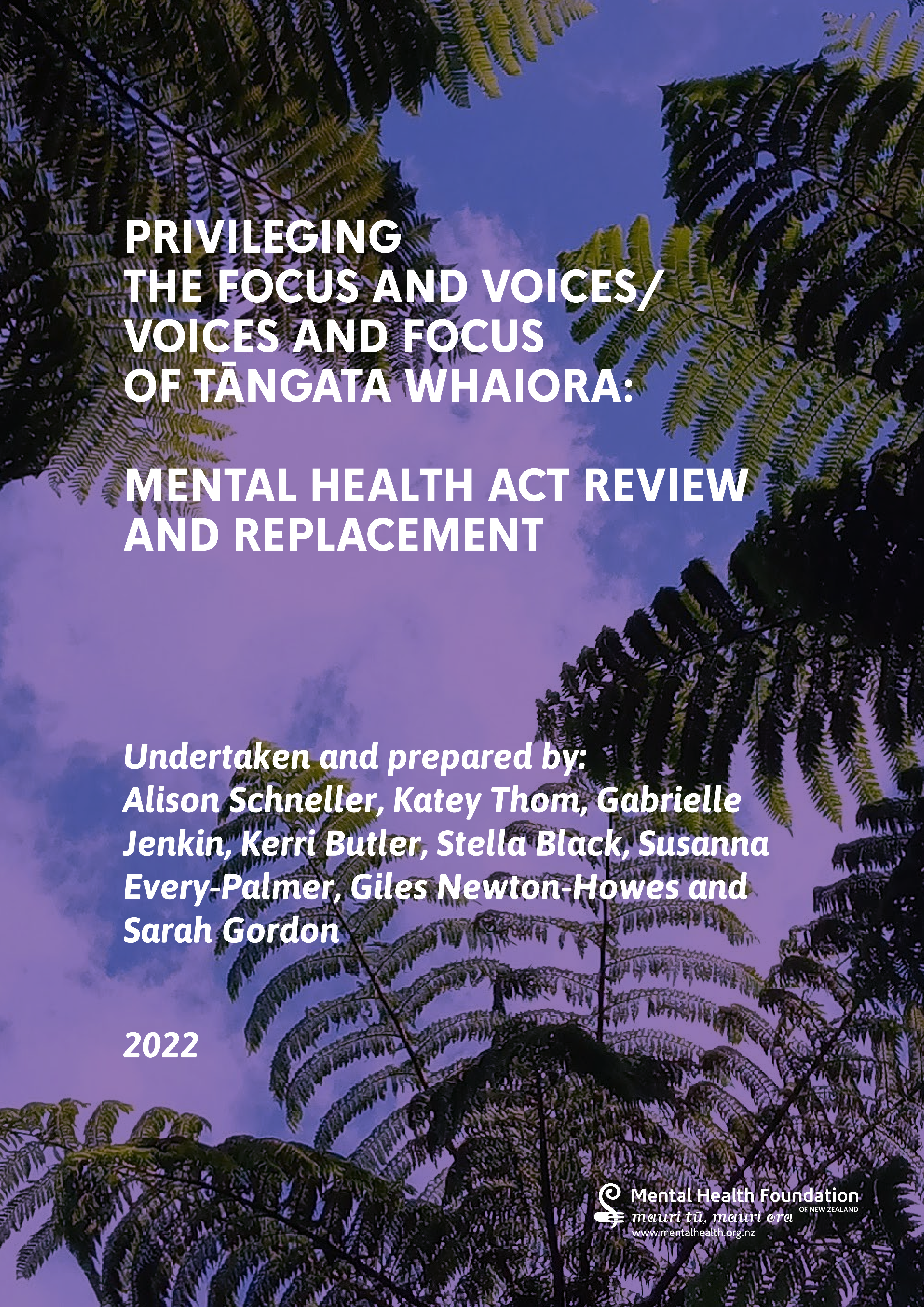

PRIVILEGING THE FOCUS AND VOICES/ VOICES AND FOCUS OF TĀNGATA WHAIORA:

MENTAL HEALTH ACT REVIEW AND REPLACEMENT

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2022

Mental Health Foundation
OF NEW ZEALAND
mauri tū, mauri ora
www.mentalhealth.org.nz

Kaua e piki ko koe kau ake, engari e piki kātahi,
me tōu iwi.

Don’t climb the mountain by yourself
but have your people climb with you.

The views written in this report are not the views of Te Whatu Ora. However, Te Whatu Ora do support raising the voices of lived experience whānau in line with the Nōku te Ao Like Minds Strategy.

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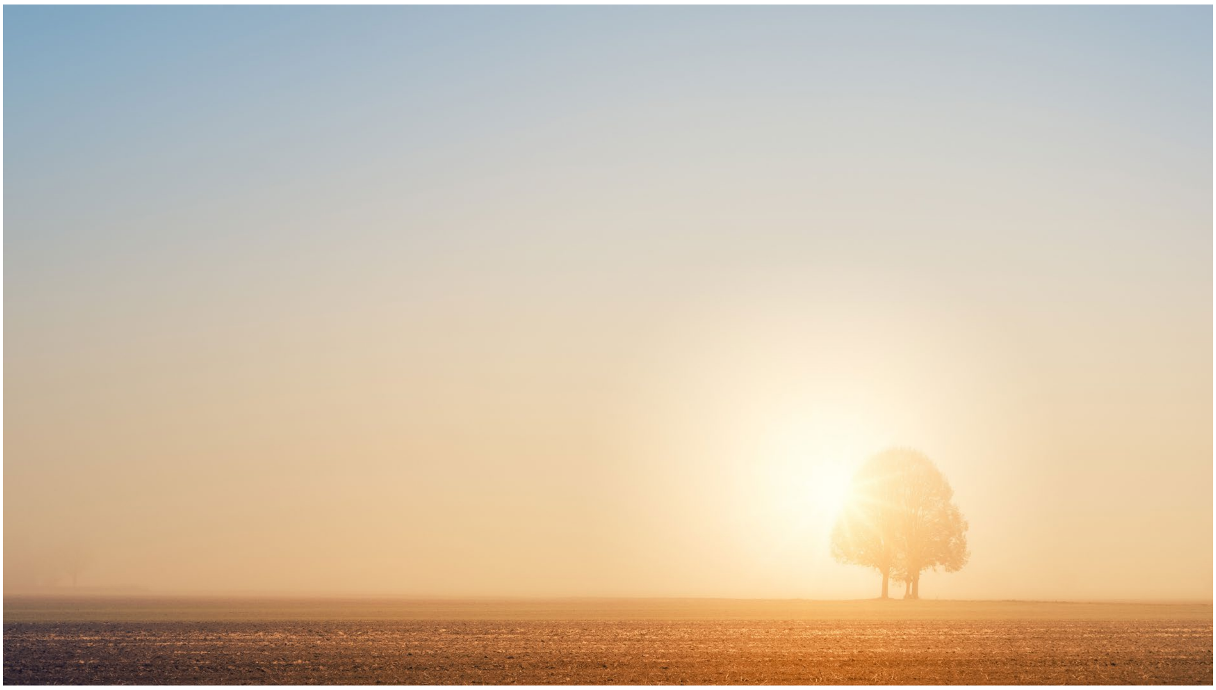

Use of terms and language

This project's primary aim was to access 'voices' of tāngata whaiora on experiences of 'compulsory treatment' enacted by mental health legislation and in particular the Mental Health (Compulsory Assessment and Treatment) Act 1992 in Aotearoa (the MHA). Compulsory treatment is the highest form of coercion in mental health services because it is legally sanctioned involuntary treatment. Excluded in the scope of this review are informal coercion practices and legally mandated restrictive practices of 'seclusion 'and/or 'restraint' terms under the MHA. We acknowledge that people can be compulsory detained for treatment or care on the basis of substance addiction and intellectual disability in Aotearoa. However, views on compulsory treatment under these enactments was not within scope of our review and nor was arbitrary detainment in a health facility.

Terms of use in project scope and this report

We acknowledge that the definition of 'compulsory treatment' has implications for proposed exclusions of research and other evidence items in at least two ways. The MHA term 'compulsory treatment' frames the issue in medico-legal terminology and practice guidelines refer to 'consensual' and 'non-consensual' treatment (Ministry of Health, 2020). This language is in stark contrast to 'forced' psychiatric treatment as a term for the experience of compulsory treatment (Minkowitz, 2006) or 'solitary confinement' in contrast to seclusion. In another way, a specific focus on compulsory treatment, limits access to stakeholder perspectives on wider concerns related to the mental health and addictions system that surface in connection with use of compulsory treatment. In *He Ara Oranga* (Government Inquiry into Mental Health and Addictions report) and related submissions documents the 'voice' extracts from stakeholder submissions emphasise concerns about system structural inequity associated with social, racial and commercial determinants of mental health and wellbeing where population groups are both overrepresented and underserved. A significant number of public health commissioned documents and reports on mental health and wellbeing exist, some specific to Māori and Pasifika populations, without including content on 'compulsory treatment' under the MHA.

We refer to **terminology in this report** and **appendices** as it is presented in literature using the authors' language. Elsewhere in the report, where we use the te reo term **tāngata whaiora**, we mean 'people seeking wellbeing when experiencing mental distress'. The word experiencing implies the use of the MHA should only be used during those times, rather than justified at any time because mental distress is seen as a permanent feature in people's daily lives. We also use the te reo term whānau as referring to close relationships of tāngata whaiora, and is sometimes used as synonymous with the English word family. We note the English word family is also used as synonymous with the Samoan word aiga (see Appendix A).

We acknowledge the term 'stakeholder' is typically used in policy documents, research and is common language within corporate and government sectors. Depending on the policy questions and interests at stake, stakeholder is a term that does not necessarily or sufficiently recognise the special status of Indigenous peoples. In addition, inclusion as a 'stakeholder' in an existing system might presume this status is not problematical for some groups of people. We are asserting an approach where regularly excluded voices, should be privileged as stakeholders. For example groups marginalised in existing mental health and addictions system, include "Māori" and "Pacific peoples" (See Schedule 2, Mental Health and Wellbeing Commission Act 2020).

Māori – collective noun for Indigenous people of Aotearoa New Zealand made up of iwi. ***Iwi*** - a tribal and kinship grouping that descends from a common ancestor, usually made up of several hapū. ***Hapū*** are clusters of whānau. ***Whānau*** – in this context relates to extended family, family group, sometimes used to include friends who may not have kinship ties to other members. We acknowledge the concept of being Māori developed a new use (as a noun) resulting from settler contact in order to distinguish between people of Māori descent and the colonisers.

Pasifika – collective noun for people with cultural identity connected to Pacific Islands. We adopt this term as used in Ka mua, Ka muri, by Nōku te Ao Like Minds below.

> *Pasifika' has been used as a term to signify those Pacific Peoples who live in Aotearoa. There are concerns with the term, however, given it privileges some language groupings, with an option to alternatively use 'Pacific Peoples' instead (as the Ministry for Pacific Peoples suggests). However, given the nature of this report, and that the latter is an English construction, we have opted to use 'Pasifika', while acknowledging these conceptual and linguistic limitations.* (Aikman, 2022, p. 6)

Mana motuhake - in this context mana relates to identity and autonomy and self-determination

Tino rangatiratanga - self-determination and right to exercise authority as an individual and as a group of people

Whakawhanaungatanga – process of establishing relationships, relating well to others.

Finally, we note that our report draws from multiple sources, and various document material in which te reo words are used. We do not provide a comprehensive glossary of all te reo terms that appear in this report and their English translations. We have endeavoured to select extracts from document material where te reo concepts and terms may be taken as understood from the context or an English translation is provided.

Key messages and recommendations

Commissioned to inform and support Nōku te Ao Like Minds - a nationwide programme to end prejudice and discrimination against people with experience of mental distress – the intended **purpose** of this work is to enable advocacy to uphold the mana and rights of tāngata whaiora in the context of the current process of repealing and replacing the Aotearoa mental health legislation.

Initially it was thought we could attend to the intended purpose of the work through a literature review of stakeholder perspectives of compulsory treatment with a focus on tāngata whaiora, people seeking wellbeing when experiencing mental distress, particularly Māori and Pasifika. However, Aotearoa and international search results show that the increasing recognised importance of the lived experience voice has so far not translated into contemporary mental health and compulsory treatment peer-reviewed qualitative research. Furthermore, the international literature studies' findings appear limited to exploring ways to improve existing compulsory treatment practices - for example, how service-user (and other stakeholder) experience can be improved to overcome or navigate the inherent ethical tensions and conflicts that surface in reality.

A small number of scholarly works have made a significant contribution using kaupapa Māori approaches and critical social theory to amplify voices absent or not well presented in mainstream research. Most of these works are Indigenous/Māori, Pasifika and/or tāngata whaiora led studies and are qualitatively different because of ways data is collected and analysed. They enable access to the reframing of views on what are primarily the negative effects of compulsory treatment experienced by those most impacted by it and, in some cases, generate proposed solutions. This includes the strong link and focus on relationship building (whakawhanaungatanga) which is seen both positively in how it supports wellbeing, and negatively in lack of appropriate engagement that is meaningful for tāngata whaiora and whānau. The issue here however is that a literature search limited to peer-reviewed published research would not yield any of these works, which are grey literature.

Given the little qualitative research evidence, we extended the project to consider the broader context for mental health law and system transformation in Aotearoa New Zealand, encompassing a review of key information and documents of pertinence, to tell a story in terms of tāngata whaiora voices and focus more generally. Drawing the historical lines together paints a picture of growing recognition of Māori and non-Māori first-hand lived experience voices and focus and we have emphasised these to the greatest extent possible throughout this section.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA) was intended to redefine the circumstances in which people could be compulsorily assessed and treated, to define rights and to provide better protection for those rights. One of the most significant elements of this new legislation was the introduction of compulsory community treatment orders.

Since 2005, when the numbers of compulsory treatment in Aotearoa New Zealand first started being reported, compulsory treatment rates have increased both absolutely and as a proportion of population numbers, with the preponderance of this increase involving community treatment orders, and making New Zealand's use of such orders amongst the highest in the world. The disparities faced by Māori in relation to legal coercion are extreme, with them being over-represented in every statistic associated with use of the MHA including both compulsory community and inpatient treatment orders and rates and duration of seclusion. With explanatory models by Māori for these disparities being race, discrimination, cultural competence in practitioners, and colonisation, the urgent need for Māori-led research into disparity rates between Māori and non-Māori has been raised. However, this has not yet resulted in any in-depth inquiry or examination that could provide critical insights into what sits behind these disparities and the resulting impact of them. Arguably, this is significant knowledge needed to inform any discussion on the subject, and the lack of it compromises the current and other associated work related to the repeal and replace process.

Internationally research studies based on aggregate data reveal there is insufficient evidence that compulsory community treatment orders are effective, with the conclusion of such studies being that given the lack of evidence, compulsory community treatment should not be used. When investigated in more depth, tāngata whaiora expressions of ambivalence and/or a preference for compulsory treatment are often about the ability to access services that are otherwise inaccessible. Despite a system that may be stretched, compulsory treatment should never be used as a mechanism to support access to treatment. The caveat that respect for rights are subject to a maximum of available resources, as applies to economic, social and cultural rights, does not apply to human rights categorised as civil and political rights as are those that are breached by compulsory treatment.

Since the Convention on the Rights of People with Disabilities (CRPD) came into force international human rights law has been interpreted as requiring the abolishment of substitute decision-making regimes (where others have the authority to make decisions about treatment and/or detention on behalf of someone else), as enabled by mental health legislation. In the alternative, supported decision-making (where people are supported, even when they lack decision-making skills, to make decisions about treatment in accord with their will and preferences) is required to replace substitute decision-making. Hence, and moreover, the Aotearoa New Zealand MHA is variously criticised for enabling and the rates of use of compulsory detention, compulsory treatment, and seclusion; and the disparities faced by Māori. Issues with review procedures have also been identified as problematic. As a result, various United Nations bodies have recommended that Aotearoa New Zealand take all necessary legislative, administrative and judicial measures to rectify the situation, often with the specification that attendance to such should be immediate.

In the context of wider sector reform, based on submissions – largely from tāngata whaiora – about the trauma of compulsory treatment and a call for the need for New Zealand legislation – and the practices enabled under it – to comply with international and domestic human rights instruments He Ara Oranga (Government Inquiry into Mental Health and Addiction) generated two recommendations in relation to the MHA:

Recommendation 34: Repeal and replace the MHA so that it 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 35: Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.

The Government accepted and prioritised the two recommendations relating to the MHA. It was determined that progressing recommendation 34 would involve a two-stage process:

1. Developing options for short-term improvements to the way the Act functions now
2. Establish a longer-term process for full repeal and replace to avoid rushing legislative change

He Ara Oranga and responses to that have identified that new legislation will not itself be transformative—it must be supported by changes in practice. To date, the short-term actions have involved a companion human rights focused guideline (to the MHA) document being produced and some amendments – supposedly to improve the protection of individual rights and the safety of patients and the public, and to enable a more effective application of the legislation – being made to the MHA.

The primary process having been undertaken for full repeal and replacement has been a public consultation. Hence, we drew on lived experience voices presented and represented in the form of 13 selected submissions to the Ministry of Health on its public consultation document. The submitters include tāngata whaiora and tāngata whaiora Māori led organisations as well as government entities with system monitoring and advocacy functions. Key areas of consensus from the submissions included that system and service transformation must occur now/alongside policy to guide new law; that there must be more recognition of Te Tiriti o Waitangi in mental health law and practice; and that supported decision-making must replace substituted decision-making (linked to solutions). Key areas of difference were that compulsory treatment should be removed absolutely from new law; that elimination should occur through a process of reduction over a period of time 5-10 years; that the use of compulsory treatment should be backed-up by stronger independent monitoring by new/existing bodies – for Māori, for seclusion/solitary confinement. Solutions for policy options included: more options for safe places to stay (not just hospital) when in severe distress; more choice and better access to holistic treatment options, especially kaupapa Māori services and treatments; more workforce development roles and leadership that recognise tāngata whaiora lived experience voice, especially of compulsory treatment.

Despite there being difference between absolute abolishment and some retention, the majority of submissions did advocate that some form and extent of compulsory treatment should remain. If some form of substitute decision-making regime were to remain there are a couple of potential issues: (i) Aotearoa New Zealand will still not be compliant with the International Convention on the Rights of Persons with Disabilities; (ii) it is possible that an exception to allow substitute decision-making within an overarching supported decision-making framework would become the default. The issue here is that our current system and services would not support transformational legislative change and hence, it is difficult to envisage such.

Interestingly Māori were more likely to advocate for complete abolishment of compulsory treatment so whilst all submissions advocated for more recognition of Te Tiriti o Waitangi in mental health law and practice, Māori were more able to articulate how this might be applied in practice and serve to be transformational. This highlights the importance of all repeal and replace work involving a partnership with Māori, including tāngata whaiora, with any new legislation needing to reflect a Māori world view and for the necessary changes in practice to be particularly considered from this perspective.

The recommendations from He Ara Oranga were arguably interdependent – e.g. people needed to engage in the national discussion to reconsider beliefs, evidence and attitudes about mental health and risk prior to embarking on their involvement in the repeal and replace process. However, to engage in such a discussion, people need to be informed – for example, to be aware of the relevant international and national law that challenges the legitimacy of compulsory treatment, the key evidence-base related to compulsory treatment, what is known about its use in practice in Aotearoa; and most especially, to hear the voices of those who have experienced compulsory treatment. This work goes some way to enabling that informed position however what we have found has also highlighted the lack of tāngata whaiora voices and focus being privileged. Unless actions are taken now to address this then we will be yet again repeating a process and generating an outcome that does not work with and for the people most affected.

Suggestions to **further advocate for the rights of tāngata whaiora and solutions for change** that follow from our review reflect that recommendation 35 from the He Ara Oranga report has not translated into meaningful action and needs to in order that we can proceed with MHA reform in an informed manner. In the first instance, we must focus on action: ***to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.*** People need to be informed in order to engage in this discussion.

- **Toward all tāngata whaiora advocacy groups:** Call to a hui 'general assembly' between groups to discuss a shared advocacy agenda on beliefs, evidence and attitudes about compulsory treatment and what replacement supported-decision making would look like in practice, when, where and for who.
    - Focus on our (tāngata whaiora) voice in the first instance. We can also advocate for others to be informed and particularly the general public but we need to think about how that should be done
    - Start with a vision – do we want revolution (no compulsory treatment) or evolution (some degree of compulsory treatment that lessens over-time). We

  need to be clear about what we might be saying either-way and what the consequences of this may be. What is the vision for us to uphold the mana and rights of tāngata whaiora in the context of the current process of repealing and replacing the Aotearoa mental health legislation.

  - Agree shared values – decide on values and keep on coming back to them in terms of decision-making and advocacy

  We suggest this as a way forward for collective interests to focus on three interconnected areas in which to develop key messages that we want to be heard 'strong and clear' amongst other voices of interest groups speaking about mental health and risk. Where possible we have made connections to literature reviewed.

  - Calling attention to the language of compulsory treatment experiences and terminology. Australian studies highlight the role and function of language to perpetuate beliefs, evidence and attitudes about mental health and risk (e.g. metaphor – unpacking ways in which compulsory treatment use/experience is described by service users and mental health practitioners). Our team reflected that this must include cultural safety and be clear it is not a translation of medico-legal terms. For example, the right to choose treatment options is also about worldview/understanding, approaches, ways of being, and language.

  - Challenging beliefs about beneficial effects of compulsory treatment (individual and society) based on research evidence, particularly focused on effectiveness of compulsory community treatment orders - *a Community Treatment Order is a legal status not a therapeutic intervention*

  - Describing the alternatives to compulsory treatment – what they need to be and what they are (those that exist already). The solutions described in this review might be drawn on as a way to identify the kinds of things that can be and must be done now, in readiness for a new law - *the abolishment of substitute decision-making does not equate to the abandonment of support*

- **Toward sector leaders, professional colleges of psychiatry and nursing, New Zealand police, mental health lawyers, Judges, district inspectors, mental health services leadership of general and service managers and clinical leaders:** There is potential to build alliances within and across these groups in relation to shaping policy solutions. These groups apply powers of compulsory treatment <u>and</u> review and monitor its use.

  - What do these groups of people need to know and do to enable our vision?

  - What alliances are important?

- **Toward policy makers:** Advocate our collective vision and values and what these mean in practice. Lobby to be kept informed on progress. Highlight the importance of all repeal and replace work involving a partnership with Māori, including tāngata whaiora, any new legislation needing to reflect a Māori world view and for the necessary changes in practice to be particularly considered from this perspective.

  - Advocate based on the fact that new legislation won't itself be transformative—it must be supported by changes in practice – this is so important
  - Know how the system, and practice specifically, needs to be different in order to enable your vision for transformation. This means working through the possible intended (and unintended) consequences of legislative change on the ground – such as in the practical implementation of 'rights'.

- **Toward actively seeking opportunities for influencing broader sector and public perceptions and/by enabling tāngata whairoa to lead discussion about compulsory treatment.** For example, through forums of community events, social media, radio, online and print publications. Audiences should include mental health service providers and community providers of social support and accommodation. **To Nōku te Ao Like Minds**: we recommend the consideration of initiatives that target attitudes about mental health and risk.
- **Toward research funders**: Little research exists about experience of compulsory treatment in Aotearoa and we must prioritise tāngata whaiora-, people seeking wellbeing when experiencing mental distress, including Māori and Pasifika particularly, led research on this subject. This would mean advocating to research funders for resource and support to be provided for tāngata whaiora to be able to undertake such research in a way where we are able to pursue investigations based on what is important to us and what we believe are essential criteria for research questions, design, methodology and production of knowledge. This review report could help inform key research questions that have not yet been answered and should be prioritised.

We make a final comment here on how to read this report. Mindful of the overall purpose of this work, we addressed the project aims by producing this foundation report as a critical discussion document. A separate supporting document contains the detail associated with the project methodology and literature search results as supplementary appendices. As a project team we are a diverse group of researchers unified by a commitment to social justice in Aotearoa. Our academic backgrounds and experience relevant to mental health law and practices of compulsory treatment, intersect knowledges in kaupapa Māori, lived experience, law, psychiatry, nursing and sociology. This combined knowledge informed our project approach - guiding the practical steps we took to do the work and our critical thinking.

Tracing a path to where we stand

Nōku te Ao Like Minds

This work was funded by Te Hiringa Hauora/Health Promotion Agency and supported by the Mental Health Foundation for Nōku te Ao Like Minds. Following 25 years of the Like Minds, Like Mine Programme, Nōku te Ao Like Minds introduces a new phase of work with and for the people most affected by discrimination, including Māori and Pacific communities. He Ara Oranga emphasises that discrimination remains widespread both in New Zealand society and the mental health system itself (New Zealand Government, 2018). This more broadly reflects the *"…harmful effects of discrimination on the basis of ethnicity, culture, disability and gender identity"* (p. 43) experienced by numerous marginalised communities. Further, the health system has consistently underdelivered for Māori and Pasifika communities who have long suffered racial discrimination in the health system, at interpersonal and institutional levels. Like Minds has been transformative in shifting attitudes about mental health, although the *"dominant Western medical model"* has underserved Māori and Pasifika whānau. Like Minds, for them, was built on a Western worldview, unable to adequately or appropriately support Māori or Pasifika peoples experiencing mental distress. He Ara Oranga emphasised the need for "*…more targeted de-stigmatisation and mental health promotion programmes … for marginalised groups"* (p. 155). It is in this context that Nōku te Ao was born, with clear calls for Māori perspectives, worldviews, and approaches to be embedded within the programme's design refresh (Aikman, 2022).

> *Rendered in English as 'The World is Mine', Nōku te Ao is being led by, and will benefit those most impacted by discrimination associated with mental distress – particularly Māori and Pasifika communities, who continue to be the most adversely affected by mental distress and discrimination today (Te Hiringa Hauora, 2021a, p. 6). The social movement this kaupapa spearheads envisions a shift in how we think and talk about issues of mental distress, away from the deficit-laden biomedical discourse that continues to dominate today. This is the embodiment of Recommendation 35 of the Inquiry: Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk. Grounded by the principles of Te Tiriti and equity, Nōku te Ao heralds a new beginning to ensure this kaupapa works with and for the people most affected by discrimination.* (Aikman, 2022, p. 7)

This is the context for this work and we begin by tracing a path that leads us to where we now stand. The repeal and replace process provides a rare and important opportunity to inform public policy and reshape practice as it relates to compulsory treatment under the Mental Health Act 1992 (MHA) in Aotearoa. In this section, we consider the broader context for this mental health law and system transformation. Of particular importance, we describe in some detail the relevant international and national law that challenges the legitimacy of compulsory treatment. We set out key evidence related to compulsory treatment, and what is known about its use in practice in Aotearoa. We include examples of lived experience evidence on the problems of compulsory treatment to demonstrate the influence these voices have had on this path. This is followed by a subsection that sets out the scope of this project to review literature on perspectives of compulsory treatment. Towards the end of this section we consider results of our literature search in the subsection on Aotearoa results: limited research and scholarly works. We begin by looking back at the MHA to help make sense of where we stand.

The Mental Health Act 1992

The 1992 Mental Health Act (MHA) placed a greater emphasis than its predecessors on 'patient' rights through strengthening processes involved in appeal and review of the legitimacy of detention and (or) treatment either via the Family Court prior to a compulsory treatment order being made, or by the Mental Health Review Tribunal. District inspectors of mental health, who are lawyers functioning as ombudsmen for the MHA, were retained to investigate complaints of breaches of patients' rights. Under section 59, after the first month of a compulsory treatment order, compulsory treatment without the patient's consent required a second psychiatrist's opinion. Sections 5 and 65, formally recognised the importance of cultural factors in diagnosis and treatment of a person's cultural and ethnic identity, including ties to whānau, hapū, and iwi (Ministry of Health, 2006). The introduction of the community treatment order in 1992 was a further development of the practice of conditional discharge from hospital, with the option of early readmission, that was well established under previous mental health legislation (O'Brien, McKenna, & Kydd, 2009). While community treatment orders allowed greater liberty than was previously possible under the 1969 Act, at the same time they permitted the duration of compulsion to be extended in the community for much longer periods of time (Ministry of Health, 2006). In 1999, an amendment to the MHA introduced section 7A, mandating consultation with family and whānau at key points of assessment and treatment.

The 1992 Act involved a new definition of mental disorder, as follows:

> an abnormal state of mind (whether of a continuous or an 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 (section 2, MHA).

How compulsory treatment works under the MHA is very briefly described to show how the procedure involves key stakeholders within scope of this project. When a person (t**angata whaiora**) is initially assessed as 'mentally disordered' (above MHA term) they are usually compulsorily admitted to a hospital, for a period of assessment and treatment, but can also be compulsorily assessed and treated in the community. Before the expiry of the assessment and treatment periods under the MHA, the **mental health clinician** responsible for the person's treatment (the responsible clinician is usually a psychiatrist) must decide whether it is necessary to continue compulsory treatment and, if so, apply to the court for an order on an inpatient or an outpatient basis. A mental health clinician must consult with a person's **family** or **whānau** before making an application for a court-order for compulsory treatment. A compulsory treatment order is an instrument or a mechanism that allows authorised mental health services to provide compulsory treatment in the hospital or community setting in respect of a person who does not agree to treatment and is 'mentally disordered'. What is included as compulsory treatment is typically prescribed medication for psychiatric illnesses, administered as tablets or intra-muscular injections.

The definition of mental disorder above intentionally avoided diagnostic labels, instead focusing on danger to self and others, and a person's capacity for self-care. While community-based compulsory commitment legislation was a response to societal demands to reduce the size of psychiatric hospitals, public concern in the 1990s-2000s was more focused on issues of risk than on the rights of service users (O'Brien et al., 2009). There was no evidence that services were less safe, for example, "*rates of homicide by mentally ill people remained unchanged, and the public were at relatively lower risk from those with serious mental illness than they were in 1970*" (Ministry of Health, 2006, p. 29). However, mental health services became risk-averse environments, and the provision of care was dominated by risk-management often at the expense of the therapeutic relationship (Hamer, 2012). Hamer argues that risk management increased the legal control of service users through the use of the MHA 1992.

Several inquiries into the deaths and maltreatment of those incarcerated in psychiatric institutions led to the Mason Inquiry in 1996. As a result, radical changes to service delivery proclaimed a stronger mental health service-user voice, and the establishment of the Mental Health Commission in 1996 for independent monitoring and implementation of a national strategy (Hamer, 2012, Brunton, 2011).

Changes in the mental health system also followed the publication of the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Mental Health Commission, 1998). The Blueprint acknowledged Te Tiriti o Waitangi as the *"original blueprint for interactions between the Crown and tāngata whenua"* (Māori) (Mental Health Commission, 1998, p. iii). The Blueprint emphasised recovery as the ability to live well in the presence or absence of one's mental illness. Central to recovery are the precepts of hope, self-determination, social connectedness, self-advocacy, education, a broader range of treatment options and the equality of service-users in the health services, and in society. The Blueprint identified discrimination as one of the biggest barriers of recovery, including that generated within mental health services (Mental Health Commission, 1998, p. 18). Mary O'Hagan, one of three Mental Health Commissioners, and a former psychiatric hospital patient and activist, subsequently authored the *Recovery Competencies for Mental Health Workers in New Zealand.* (O'Hagan, 2001)

From early 2000s, national mental health policy placed a strong focus on improving information use in mental health to achieve better-quality services with improved outcomes, as well as being better able to demonstrate the value of services (Ministry of Health, 2006, p.

6). In 2006, New Zealand's first extensive epidemiological survey, Te Rau Hinengaro (Oakley Browne et al.) provided internationally comparable information on the rates and severity of illness (including substance disorder) and treatment received among those aged 16 and over living in the community (Kingi, 2018a).

However, during the next two decades the powers, effectiveness and funding of the Mental Health Commission were reduced (New Zealand Government, 2018, p. 199). Prior to being disestablished in 2012, the Commission published Blueprint II that focused on strategies for recovery, addressing discrimination and the specific needs of Māori and Pasifika. The role of Mental Health Commissioner was subsumed under the Office of the Health and Disability Commissioner, with a narrower focus on service-users rights in provision of mental health and addiction services.

In his 2016 annual report, the Director of Mental Health reported that the sector faces *"new and shifting challenges"* such as: increasing pressure on specialist mental health care and addiction services, continuing inequitable mental health outcomes for Māori, Pasifika, disabled people, and refugees among population groups that disproportionately experience mental health issues, and meeting moderate mental health needs of the population not easily managed in primary care, but not meeting the threshold for specialist care (Ministry of Health, 2017a, p. 3). These challenges are starkly represented by data on increasing and disproportionate rates of compulsory treatment and seclusion.

Rates of compulsory treatment and seclusion

Since 2005, when the numbers of compulsory treatment in Aotearoa New Zealand first started being reported, compulsory treatment rates have increased from 82 per 100,000 in 2005 to 103 per 100,000 in 2020 - an increase that is both absolute and as a proportion of population numbers (Ministry of Health, 2021). The preponderance of this increase involves community treatment orders (91 per 100,000) and makes New Zealand's use of such orders amongst the highest in the world (O'Brien, 2014). In 2020, people aged 25–34 years were the most likely to be subject to a compulsory treatment order (185.2 per 100,000). In terms of gender, males were more likely to be subject to a compulsory treatment order (108 per 100,000) than females (80 per 100,000). Māori were 1.8 times more likely than Pasifika to be subject to a community treatment order and 4.1 times more likely than other ethnicities; and 1.8 times more likely than Pasifika to be subject to an inpatient treatment order and 3.5 times more likely than other ethnicities (Ministry of Health, 2021).

In 2020, the rates of people subject to compulsory treatment orders varied from 55 per 100,000 to 197 per 100,000 across the 20 DHBs (Ministry of Health, 2021). Up until October last year, the MHA allowed for community treatment orders to become 'indefinite'. In 2020, 57 percent of all individuals on community treatment orders and 29 percent on inpatient treatment orders were subject to indefinite treatment orders. The average period for indefinite community treatment orders was just over 4 years and the maximum period was approximately 27 years. Māori were 2.9 times more likely to be subject to both indefinite community treatment orders and indefinite inpatient treatment orders than non-Māori

(Ministry of Health, 2021). The Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021 now requires the Courts to review such orders at the end of each 12-month period for the duration of the order.

In adult inpatient services (excluding forensic and other regional rehabilitation services) in 2020, 933 adults were secluded at some stage during 1 January and 31 December 2019. Among the adults who were secluded, many were secluded more than once (on average 2.2 times). The total number of seclusion events was 2,075. From 2007 to 2020, the number of people secluded decreased by 18 percent. However, the number of people secluded who identified as Māori increased by 15 percent over the same period. Despite the apparent decrease in response to the seclusion reduction policy introduced in 2009, since 2014 seclusion rates have been on the increase again, with the number of adult inpatient clients secluded increasing by 9 percent from 2018 to 2019, and the number of hours spent in seclusion increasing by 19 percent. For 2020, there was no discernible percentage difference in the number of adult inpatient clients secluded from 2019 to 2020, however the number of hours spent in seclusion decreased by 7 percent (Ministry of Health, 2021).

Of the 1179 persons secluded across all inpatient services, including forensic, intellectual disability and youth services, 66 percent were male, and 34 percent were female. The most common age group for those secluded was 20–24 years. A total of 103 young people (aged 19 years and under) were secluded during the 2020 year in 147 seclusion events. Māori were 5.1 times more likely to be secluded in adult inpatient services than non-Māori and non-Pacific peoples. Māori were five times more likely to be secluded in adult inpatient services than people from other ethnic groups. The rates of people secluded varied from 4.2 – 84.3 per 100,000 across DHBs (Ministry of Health, 2021). Research has identified that sociodemographic and clinical factors are not influencing this variation in seclusion rates across DHBs (Lai et al., 2018). Rather, the authors hypothesised that what was in fact influencing this variation was differences in service delivery models and practice approaches. We also hypothesise it is racism and discrimination that are the key drivers for the inequitable use of seclusion with Māori and Pasifika whānau.

> *Explanatory models for the high rates of Māori compulsion and seclusion have focused generally on markers of social deprivation, with the exception of Māori authors such as Durie, Kingi, Elder and Tapsell who identify the influence of race, cultural competence in practitioners, and colonisation as significant in the way mental health services assess, respond to and treat Māori.* (Mental Health Foundation, 2016, p. 32)

In 2013, Elder and Tapsell (2013) called for urgent Māori-led research into disparity rates between Māori and non-Māori, however, this has not yet resulted in any in-depth inquiry or examination that could provide critical insights into what sits behind these disparities and the resulting impact of them. Arguably, this is significant knowledge needed to inform any discussion on the subject, and the lack of it compromises the current and other associated work related to the repeal and replace process.

Evidence base in support of compulsory treatment

Given the preponderance of compulsory treatment in New Zealand involves community treatment orders, this section of the report is primarily based on a review of literature pertaining to that type of order. The most recent Cochrane systematic review (that which is held in the highest esteem in academia) reviewed *"[a]ll relevant randomised controlled clinical trials (RCTs) of CCT [compulsory community treatment] compared with standard care for people with SMI [serious mental illness] (mainly schizophrenia and schizophrenia-like disorders, bipolar disorder, or depression with psychotic features). Standard care could be voluntary treatment in the community or another pre-existing form of CCT such as supervised discharge"* (Kisely, Campbell, & O'Reilly, 2017, p. 1). In practice, this involved a review of three studies - two from the USA and one from England. No differences were found in outcomes between those detained and those treated voluntarily at about a year. This included the outcomes of: readmission to hospital, adherence with medication, arrested (once or more), homelessness, or satisfaction with care. One trial reported a reduced risk of revictimisation. When follow up went to three years the lack of difference persisted. The review reports 142 orders would be required to prevent one readmission. Of note, none of the outcomes were rated as strong.

A broader systematic review that included both the randomised and non-randomised studies concluded that *"[t]here remains a lack of evidence from randomised and non-randomised studies that [community treatment orders] are associated with or affected by admission rates, number of inpatient days or community service use"* (Maughan, Molodynski, Rugkasa, & Burns, 2014, p. 651). A systemic review of studies of community treatment order use in Australia and New Zealand concluded that *"[c]ommunity treatment orders did not reduce readmission rates or bed-days at 12-month follow-up. There was evidence of increased benefit in the longer-term but only after a minimum of 2 years of use"* (Kisely, Yu, Maehashi, & Siskind, 2021, p. 650). Interestingly there was a signal for lower mortality in the detained group. The authors suggest *"[t]he restrictive nature of community treatment orders may not be outweighed by the inconclusive evidence for beneficial outcomes"* (p. 650).

Taken as a whole the systematic review evidence is remarkably consistent in suggesting that community treatment orders do not provide any clear benefit to people in psychosocial distress, and this is also true in the Australasian setting.

Lower in the academic hierarchy of evidence are cohort studies. These studies do suggest community treatment orders increase contact with community mental health teams (Beaglehole, Newton-Howes, & Frampton, 2021). This has been interpreted in different ways by different authors. Some suggest this shows that people detained on community treatment orders are more unwell. This might be true, but it does not mean the community treatment orders improves outcomes, only that this correlation exists. Others have suggested that being subject to a community treatment order increases access to care within a stretched health care service, and some patients prefer to be subject to a community treatment order, even though it results in the loss of their right to make decisions (despite probably having the capacity to do so), just so they are able to access services. This situation has been described as kafkaesque, that is reminiscent of Franz Kafka's oppressive, complex, bizarre and bureaucratic fictional world depicted in *The Trial*.

> *...even if CTOs do provide those subject to them with some benefit, it may be that that benefit derives not from their coercive effect per se, but via an administrative mechanism that simply signals to community health services that these patients should have priority access to their care. As a result of that administrative signal, patients on CTOs may get more services and any beneficial effect of a CTO may be simply down to that. The notion that patient rights are being routinely abrogated to allow services to better organise their resources is nothing short of Kafkaesque. The fact that this form of triage results in no, or only marginal, benefit is to add insult to injury both for the individual and to a system that tacitly accepts the delivery of a two-tiered system of care. Moreover, this ranking by legal status perversely encourages patients and their families to accept a CTO in order to access greater service provision.*
>
> *The options presented to patients frequently presume only two choices – hospital or a CTO – while ignoring the obvious third choice, voluntary community treatment without a CTO. This false dichotomy levers patients and their families to access a CTO where they may prefer not to, fearing the loss of service provision. Recognition of the rights of patients to make informed choices not only reflects a literature that suggests that a high proportion of patients with mental illness retain decision-making capacity, but it is consistent with a recovery focus, as recovery becomes a guiding principle for mental health services.* (Newton-Howes & Ryan, 2017, p. 311-312)

An Australian study examining stakeholder perspectives on how the mental health system affects the use of involuntary community treatment orders (CTOs) identified two key themes - that (1) CTOs are used to increase access to services; and that (2) CTOs cannot remedy non-existent or inadequate services. As a result the authors conclude:

> *...deficiencies in health service structures and resourcing are a significant factor in CTO use. This raises questions about policy accountability for mental health services (both voluntary and involuntary), as well as about the usefulness of CTOs, justifications for CTO use and the legal criteria regulating CTO implementation.* (Light, Robertson, Boyce, Carney, Rosen, Cleary, et al., 2016, p. 351)

Conclusions then in relation to the quantitative research – considering arguments both for and against community treatment orders – were that the scientific evidence that community treatment orders work is weak at best. The findings from the key studies upon which this conclusion is based included:

a) The number of non-randomised studies that have provided negative and conflicting results and thus have not provided sufficient evidence to support community treatment orders;

b) The three independent randomised controlled trials and the meta-analysis of their data that have shown no benefit of community treatment orders on the number of hospital admissions and other relevant outcomes including service use, social functioning, mental state, homelessness, satisfaction with services or perceived coercion; and

c) Patients on a community treatment order show even less adherence to depot injections than those not on a community treatment order (Heun, Dave, & Rowlands, 2016).

Similarly, based on an appraisal of the current literature on community treatment orders from the viewpoint of evidence-based medicine, it was concluded that:

> *...the lack of evidence for patient benefit, particularly when combined with restrictions to personal liberty, is striking and needs to be taken seriously. Clinicians have a duty to provide their patients with treatment in the least restrictive environment. The paucity of rigorous experimental research evidence for such an invasive intervention that has been in use for over three decades is quite remarkable. It raises a question of whether this would have been accepted in other branches of medicine. Surely major, intrusive interventions in community psychiatry should be expected to conform to the highest standards of evidence... If clinicians are to take a strictly evidence-based approach, then they cannot continue to use CTOs in their current form.* (Rugkåsa, Dawson, & Burns, 2014, pp. 1868-1869)

The initial focus of the present work did not include qualitative research involving survey-based interviews, however such work has been completed and provides additional insights into compulsory care within an Aotearoa New Zealand setting. A co-designed approach was undertaken, with service users to develop the methodology and areas of interest. Ultimately the perspectives of 79 patients, from a possible total of 103 candidates agreed to participate of whom 33 identified as Maori. Interestingly this group had mixed views of CTO use (Newton-Howes & Banks, 2014). Of those patients who were in employment and described greater coercion and less satisfaction with care, more than half considered CTOs negatively. Given the forced choice of compulsion or not, views were almost evenly split, making it clear that not all service users disliked the loss of freedom a CTO entails but objective benefit seemed important (like being in work). Factor analysis of the same dataset, a methodology to group large data, identified three clear latent factors associated with CTOs (Newton-Howes, 2013). These were labelled 'interpersonal difficulties', intrapsychic threat', and 'safety'. In other words, it was clear this Aoteroa New Zealand population found CTOs caused problems to relationships and threatened them, but also provided some safety, likely related to the ability to access services. These findings reflect a wider systematic review and thematic analysis by the same team, that found overarching themes of 'disrespect', 'humiliation' and 'loss of human contact' as prominent in the qualitative literature, with minor positive themes of 'a rationale for treatment' and 'to protect' also identified (Newton-Howes & Mullen, 2011).

It should be noted that we did not review all the effectiveness literature, particularly that related to compulsory inpatient treatment, and we note the complexity and nuances in the study of the subject.

Another challenge unfolding is how the MHA 1992 relates to the New Zealand Bill of Rights Act 1990 and the United Nations (UN) Convention on the Rights of People with Disabilities. Since Aotearoa New Zealand's ratification of the Convention on the Rights of People with

Disabilities in 2008, UN bodies have recommended that Aotearoa review the MHA to ensure it complies with the UN Convention (Ministry of Health, 2017b).

Prior to moving onto that subject however, Peter Bartlett has concluded:

> *It is fair to say that much of the compulsion now used may be difficult to justify on evidential grounds, quite apart from the CRPD. Community treatment orders seem never quite able to show that they improve outcomes following discharge, and the limited evidence available suggests that it is similarly doubtful how much good comes from involuntary psychiatric admission. While these techniques have been used for many years, it may be the case that they are not as essential as seems to be assumed.* (Bartlett, 2017, p. 220)

International Human Rights and Aotearoa compliance

The Committee of the Convention on the Rights of Persons with Disabilities (CRPD) has provided detailed advice as to what is necessary for mental health regimes to be compliant with the CRPD (Committee on the Rights of Persons with Disabilities, 2014). Legal capacity, which encompasses both legal standing (the holding of rights) and legal agency (the exercising of rights), cannot be denied under any circumstances. This includes in relation to the right to give consent for medical treatment. One of the most significant issues with the MHA is that a person's legal agency is denied when the right to refuse medical treatment of the New Zealand Bill of Rights Act is overridden by provisions of the MHA being applied to compel treatment, even when a person has mental capacity/decision making skills, or in other words, is 'competent'.

However, the position of the Committee of the Convention on the Rights of Persons with Disabilities goes much further with their guidance being that:

- The existence of a disability shall in no case justify a deprivation of liberty
- The unlawful detention and /or treatment includes situations where the deprivation of liberty is grounded in the combination between a mental disability AND other elements such as dangerousness, or the need for care and treatment (as is the case with the New Zealand Mental Health Act)
- Earlier on there was some suggestion that substitute decision-making regimes may be compliant with the CRPD if they were capacity based – e.g. if a person was assessed as lacking what is known as treatment decision-making skills or what is commonly referred to as 'mental capacity'. However, the Committee has made it clear that that is not the case:

> *In most of the State party reports that the Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. This is decided simply on the basis of the diagnosis of an impairment (status approach), or where a person makes a decision that is considered*

> *to have negative consequences (outcome approach), or where a person's decision-making skills are considered to be deficient (functional approach). The functional approach attempts to assess mental capacity and deny legal capacity accordingly. It is often based on whether a person can understand the nature and consequences of a decision and/or whether he or she can use or weigh the relevant information. This approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right — the right to equal recognition before the law. In all of those approaches, a person's disability and/or decision-making skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law. Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.* (p. 4)

So, substitute decision-making regimes are completely prohibited by the CRPD. Even where there is an assessment of perceived or actual impaired mental capacity/decision-making skills, it should result in the provision of the support necessary to enable the individual to make a decision in accord with their will and preferences (supported decision-making) as opposed to this then resulting in a denial of legal capacity and justifying others making decisions on behalf of the individual (substitute decision-making).

In 2006, *No Force Advocacy by Users and Survivors of Psychiatry*, was published by the Mental Health Commission Wellington, New Zealand. The lead author, Tina Minkowitz, a psychiatric survivor and human rights lawyer, was a member of the working group that produced the first official text of the United Nations Disability Convention. The Mental Health Commission report includes commentaries by Peter Bartlett, professor of mental health law, David Codyre, consultant psychiatrist, Ian Curtis, consultant psychiatrist, Tony Ellis, human rights barrister, Mental Health Commission of New Zealand.

Minkowitz considers some of the issues related to the use of legal compulsory interventions by mental health services and related legal frameworks that restrict personal autonomy. Emphasising a human rights perspective throughout, the paper examines the arguments of users and survivors of psychiatry advocating that no force be used in mental health interventions. "No-force" is the campaign to eliminate all forms of coercive psychiatry and legal disqualification.

In her paper, Minkowitz proposes that supported decision-making can be understood, from a user/survivor point of view, as an application of the recovery perspective to the situation of decision-making.

> *The recovery perspective is centred on individual strength and capability and the belief that madness is a temporary state of distress and disruption. It emphasizes hope and cultivation of the person's own abilities of self-reflection and development of skills particularly with experiences that might otherwise gain power over the individual. Like recovery, supported decision-making is centred in respect for self-*

> *determination and for the inherent human capabilities of each individual.* (Minkowitz, 2006, p. 12)

Supported decision making, and what is at stake for those with psycho social disability, is explained powerfully and simply by Minkowitz, as a result of her deep involvement in the drafting of the United Nations Disability Convention. In Minkowitz's own words:

> *The twin premises of supported decision-making are that everyone has legal capacity and that everyone is entitled to use support of their choosing when making and communicating their decisions. Support cannot be imposed over a person's objections, and a support person cannot act against the person's will or override his or her decisions. The supported decision-making model was developed as an alternative to guardianship, and it remains relevant in that respect to both users and survivors of psychiatry and other people with disabilities.*
>
> *Legal capacity has emerged as a central issue in the convention, because it challenges the depth of society's lack of commitment to full equality for people with disabilities. What does it mean to say that disability is a social phenomenon that can be addressed through supportive accommodations? Legal frameworks are part of the social environment that must be re-examined and redesigned for accessibility. The disability movement has developed the concept of supported decision-making as a way of redesigning legal capacity so that it is accessible to all people with disabilities.*
>
> *However, legal capacity also affects other areas of life where legal disqualification is imposed or a determination made about competence. The supported decision-making model would abolish all tests of legal capacity or determinations of incapacity, while ensuring that support is available as an entitlement to all who wish to use it.* (Minkowitz, 2006, p. 12)

Minkowitz's account links to our opening comments on mental health regimes compliance with the CRPD.

To emphasise the point, it is at the junction of an assessment of perceived or actual impaired decision-making skills where the expectation of the committee of the CRPD changes radically from what is the norm. Rather than this then resulting in a denial of legal capacity and justifying others making decisions on behalf of the individual (substitute decision-making), it should result in the provision of the support necessary to enable the individual to make a decision in accord with their will and preferences (supported decision-making).

Table 1 provides a summary of the key differences between substituted and supported decision-making.

From substitute decision-making	To supported decision-making
A presumption that people with psychosocial disabilities don't have the mental capacity / ability to make their own decisions.	A presumption that people with psychosocial disabilities can make decisions by themselves and for themselves, with the assistance of support if needed.
Assessing deficits in mental capacity (ability to make decision)	Exploring the type and level of support that may be required to make decisions
Best interests (Where others determine what s the best decision or course of action for a person)	**Will and preference** (Where all decisions are based on the will and preferences of the person or in some cases on the best interpretation of their wished and preferences in situations where it is not practicable to determine the will and preference of an individual)
Substitute decision making and appointment of substitute decision makers (Where other people make decisions for you according to their own standards and not your will and preferences)	Supported decision making (Where people make decisions for themselves and by themselves with support)
Adapted from Lewis O., Bach M., *How Northern Ireland can avoid making a big "mental capacity law mistake"* [website]. Northern Ireland; Oliver Talks; 2014.	

A number of United Nations (UN) committees and working parties have identified that the Aotearoa MHA is problematic in several ways: Committee on the Rights of Persons with Disabilities, 2014; Committee against Torture, 2015; United Nations Working Group on Arbitrary Detention, 2014). It contravenes a number of International Human Rights Conventions that Aotearoa New Zealand is a signatory to and has ratified, thereby taking an obligation under international law to implement them, including the Convention on the Rights of Persons with Disabilities, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the United Nations Declaration on the Rights of Indigenous Peoples. In particular, the MHA is variously criticised for enabling and the rates of use of compulsory detention, compulsory treatment, and seclusion; and the disparities faced by Māori. Issues with review procedures have also been identified. In practice, compulsory treatment orders are largely clinical decisions, and it is difficult to effectively challenge such orders. As a result, it has been recommended that Aotearoa New Zealand take all necessary legislative, administrative and judicial measures to rectify the situation, often with the specification that attendance to such should be immediate. The caveat that respect for rights are subject to a maximum of available resources, as applies to economic, social and cultural rights, does not apply to human rights categorised as civil and political rights as are those that are breached by compulsory treatment.

> *Human rights have become divided into those that are civil and political (including such matters as the right to liberty) and those that are economic, social and cultural*

> *(such as rights to housing), the distinction being that rights in the former group cannot be defeated by any lack of resources. Accordingly, Article 4(2) of the CRPD indicates that rights which are economic, social and cultural are to be implemented by the state using "the maximum of its available resources" to realise them progressively, whereas civil and political rights, such as the right to equal recognition before the law (which requires substitute decision making being abolished and replaced with supported decision making), have no such resource-based limitations.* (Gordon et al, 2022, pp. 12-13)

The International Monitoring Mechanism (IMM) of the Convention on the Rights of Persons with Disabilities – Aotearoa New Zealand, consisting of the Human Rights Commission, the Office of the Ombudsman and Disabled People's Organisations (DPOs), have been advocating for the New Zealand Government to be responsive to the UN recommendations.

In 2017, the Ministry of Health released its analysis of submissions received in response to its discussion document on the MHA and Human Rights (Ministry of Health, 2017b). A key theme was inconsistencies between the MHA and New Zealand's human rights obligations under the Convention. Submissions also called for increased recognition of the views and preferences of service-users, informed consent, and greater choice in treatment options—not just medication. The detrimental impacts of compulsory treatment in the case of community treatment orders were described in the following extract:

> *[CTOs] create a sense of shame and powerlessness that you can't manage your mental illness and medication independently... [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, 2017b, p. 4)

Another key theme covered lack of access to early intervention services which were seen as contributing to rates of treatment under the MHA. Acknowledged service gaps were summarised in submissions on need to improve family consultation under the MHA and need to strengthen cultural responsiveness, competency, and assessment, including Indigenous approaches.

Current context for mental health and law transformation

The existing health and disabiliy services system failure to effect better outcomes for Māori was criticised by the Waitangi Tribunal in its 2019 report *Hauora: Report on Stage One of the Health Service and Outcomes Kaupapa Inquiry* (Waitangi Tribunal, 2019), as a breach of the Crown's obligations as a partner to *Te Tiriti o Waitangi*.

The Tribunal's main finding in Hauora was that the Crown had breached the Treaty of Waitangi by failing to design and administer the current primary health care system to actively address persistent Māori health inequities, and failing to give effect to the Treaty's guarantee of tino rangatiratanga (autonomy, self-determination, sovereignty, self-government). It also found that the Crown had failed to guarantee Māori adequate decision-making authority regarding the design and delivery of primary health services and to properly support and resource Māori primary health organisations and health providers.

The Waitangi Tribunal identified **recognition and protection of tino rangatiratanga**, and the **Treaty principles** of **partnership**; **active protection**; **equity**; and **options**, as particularly applicable to its inquiry (Waitangi Tribunal, 2019, p. 27). The next stage of the Waitangi Tribunal's inquiry into health outcomes for Māori relates to mental health and addictions services.

In 2018, the Government announced a wide-ranging review of the Health and Disability system in New Zealand, designed to future-proof our health and disability services. The Review looked at the overall function of the health and disability system and whether the system is balanced towards wellness, access, equity, and sustainability. The final report on the findings of the Review was released on 16 June 2020.

In April 2021, the Government announced a major transformation of the health and disability system in response to the Health and Disability System Review. The Pae Ora (Healthy Futures) Act took effect on 1 July 2022 establishing four new entities:

- A new Public Health Agency within the Ministry to lead and strengthen public health
- Te Whatu Ora – Health New Zealand as the national organisation to lead and coordinate delivery of health services across the country, in co-governance with Te Aka Whai Ora
- Te Aka Whai Ora – Māori Health Authority as an independent statutory authority to drive equity, in partnership with Te Whatu Ora, for Hauora Māori through monitoring and commissioning functions.
- Whaikaha – Ministry of Disabled People to provide a wider lens on disability across Government and drive transformation of the disability support system.

The Pae Ora Act recognises the role of Iwi–Māori Partnership Boards to act as a vehicle for Māori to exercise **tino rangatiratanga** and **mana motuhake** with respect to planning and decision-making for health services at the local level. The 20 district health boards were disestablished, and Health NZ now operates hospitals and health services. Around 60–80 localities will be established in communities around the country to provide advice on the health services needed.

Mental health law reform is occuring within this broader context of structural change.

He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction (2018)

Following widespread concern, in 2018 the Government announced an Inquiry into mental health and addictions to build public consensus on the specific changes in mental health needed to address inequalities, prevention of suicide and enable improved outcomes (Prime Minister, 2018). Based on extensive public consultation the inquiry panel identified that strong themes emerged in relation to wellbeing and community solutions; Māori health and wellbeing; Pacific health and wellbeing; the social and economic determinants of health; addictions; families and whānau; children and young people; support in the community; access, wait times and quality; workforce; human rights and mental health; and leadership and oversight. *He Ara Oranga: The report of the Government Inquiry report into Mental Health and Addiction* recommended 40 actions for mental health and wellbeing for all, covering 12 broad areas: Expand access and choice, transform primary health care, strengthen the NGO sector, take a whole-of-government approach to wellbeing, facilitate mental health promotion and prevention, place people at the centre, take strong action on alcohol and other drugs, prevent suicide, reform the Mental Health Act, establish a new Mental Health and Wellbeing Commission, refer to the Health and Disability Sector Review, and establish a cross-party working group on mental health and wellbeing (New Zealand Government, 2018).

He Ara Oranga supported an approach from 'big psychiatry' to 'big community' called for in the submission Wellbeing Manifesto for Aotearoa New Zealand developed by Mary O'Hagan in consultation with tāngata whaiora, Māori, Pasifika, health promotion experts, mental health professionals and mental health system leaders (New Zealand Government, 2018, p 36; see O'Hagen, 2018). Several recommendations aim to strengthen consumer participation and voice and family support. The He Ara Oranga report acknowledges the Health and Quality Safety Commission's 2015 guide to DHBs consumer engagement and highlights further specific measures to support consumers and people with lived experience to play a greater role in policy, governance, service planning and delivery and to enhance consumers' knowledge about their rights (Recommendations 20 and 21). Partnering with families and whānau in supporting people experiencing mental health and addiction issues is stated as a priority, as is providing more support for families and whānau themselves (Recommendations 23 and 24).

In terms of compulsory treatment particularly, it was reported that:

> *Throughout this Inquiry, many people shared their experiences of being held and compulsorily treated under mental health legislation. Submitters described the*

> *trauma of compulsory detention and treatment, the loss of their right to participate in decisions about their treatment and recovery, the adverse impacts of forced medication, and the harm and powerlessness they experienced through practices of seclusion and restraint and prolonged use of the Mental Health Act...* (p. 189)

Furthermore:

> *Many submitters across the country emphasised the need for New Zealand legislation – and the practices enabled under it – to comply with international and domestic human rights instruments. In particular, national consumer groups and individuals... resoundingly called for the urgent review and replacement of the Mental Health Act.* (pp. 189-190).

He Ara Oranga concluded that the MHA is out of date, inconsistent with New Zealand's international treaty obligations and sometimes results in trauma and harm to people who are subject to the Act. The use of compulsory treatment orders varies around the country, and seclusion and restraint are used too often, especially for Māori and Pacific peoples. *He Ara Oranga* also highlighted that the Ministry of Health discussion document released in 2016, followed by the thematic analysis of submissions, outlined many of the same issues. As a result, there were two recommendations in relation to the MHA:

Recommendation 34: Repeal and replace the MHA so that it 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 35: Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.

In response to *He Ara Oranga*, the Government established a new Mental Health and Wellbeing Commission under the Mental Health and Wellbeing Commission Act 2020. The Government accepted and prioritised the two recommendations relating to the MHA. It was determined that progressing recommendation 34 would involve a two-stage process:

1. Developing options for short term improvements to the way the Act functions now
2. Establish a longer-term process for full repeal and replace to avoid rushing legislative change.

He Ara Oranga (the national mental health inquiry) and responses to that have identified that new legislation won't itself be transformative—it must be supported by changes in practice (Initial Mental Health and Wellbeing Commission, 2020).

Voices of Māori and Pasifika in He Ara Oranga

In this section we highlight three reports focused on Māori and Pasifika collective voices, each generated as a result of the national Inquiry process that culminated in the He Ara Oranga report and recommendations.

The report *Oranga Tāngata, Oranga Whānau* (Inquiry into Mental Health and Addiction, 2019) makes visible and audible the voices of whānau, kaimahi and iwi who made submissions to the Inquiry:

> *Collectively, they called for transformational change in the health system in order for Māori to achieve optimal wellbeing. Their view is that a paradigm shift is needed towards a system grounded in tikanga Māori values; one that is holistic, whānau-centred and decolonising, and which takes a life-course approach to wellness.* (p. 2)

The report concludes that those who made submissions to the Inquiry highlighted the shortcomings of a dysfunctional system in which Kaupapa Māori services are stretched, under-acknowledged, under-resourced and constrained in a system founded on principles that conflict with inherent Māori values.

> *Kaupapa Māori solutions are required for Māori to live in a society that is founded on the principles handed down from the ancestors, and one in which there will be ready access to all the determinants for good health and wellbeing.*
>
> *Whānau have expressed considerable concerns about a system that is overly focussed on pharmaceutical solutions, is difficult to navigate, is colonising, racist, and does not respond to needs in a timely or effective manner. We are made to feel disempowered in a system that doesn't acknowledge mana Māori and in fact, has in many cases caused further harm.* (p. 72).

The report's strong message is that Māori solutions will work for whānau, and will offer approaches that are inclusive of all.

Another, independently released technical report that draws together Māori aspirations for the Inquiry is entitled *Whakamanawa* (Russell, Levy & Cherrington, 2018). The title of the report – Whakamanawa – means 'to honour'. It is the collective voice of Māori with lived experience, whanaunga of those with lived experience, whānau bereaved by suicide, and kaimahi Māori working in the mental health, addiction and suicide prevention sectors, including researchers, that is intended to be honoured through this work.

Whakamanawa draws out both the challenges and solutions for mental distress, addiction and suicide in Aotearoa, as voiced by whānau, hapū and Iwi Māori, alongside Māori working in the mental health, suicide prevention, addiction, health and other social service sectors.

> *When Māori access secondary services, they do so by way of coercive means and have a significantly higher risk of receiving a diagnosis of a serious mental illness, in addition to having a differing experience of care when compared to non-Māori (e.g., high seclusion and restraint, and use of the Mental Health Act).* (Māori organisation/service provider/group) (p. 171)

In the report Māori voice comments on the way in which community treatment orders transgress tikanga and mana, and are considered discriminatory. For example, a lack of accountability and misuse of power by psychiatrists who hold all the power in courtrooms where such orders are made is identified, along with no consideration and weight being accorded to whānau expertise. At times seclusion is the result of a lack of appropriate space being available elsewhere.

> *I stand to represent not only myself but other vulnerable persons who have [been] degraded by people in positions of authority who are funded by the taxpaying Government ...I felt ashamed and fearful. My mental state of mind further deteriorated due to their response. I felt traumatised and felt that my basic human rights as a woman had been blatantly violated.* (Māori with lived experience) (p. 717)

He Ara Oranga also released a collective report submitted as part of the Inquiry titled Mental Health Inquiry Pacific Report Pacific Submission (Inquiry into Mental Health and Addiction, 2019a). This report summarises and synthesises Pacific online submissions, emails, oral contributions in fono/meetings and written submissions.

> *Pacific practitioners working on the front lines of acute units spoke with concern about the genuine lack of compassion shown to Pacific peoples experiencing mental anguish. They talked about the lack of safety for these vulnerable peoples in a mainstream system if Pacific staff weren't present. They expressed concern about the way the Mental Health Act was wielded. The Mental Health Act is as 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.* [Pacific Provider] (pp. 29-30)

The report summarised participants concerns about how the existing system further traumatises Pasifika and their families who are in pain and identified that the ways Pasifika were treated were in direct contradiction to Pacific values of respect, humility and dignity. These humanistic considerations seemed undermined by practices that enabled certain worldviews or ways of being to dominate to the detriment of others.

The above reports and extracts of Pasifika and Māori collective voices (lived experience and provider experience of MHA use) can be read as evidence of systemic and systematic racial bias operating in institutional processes and practices in which Māori and Pasifika are under-served and, as a result, over-represented in data on MHA use. The ways in which the MHA power is 'wielded' in practice within the system perpetuates inequities and we need big Māori, big Pasifika and big lived experience voice to make for big advocacy in relation to changes in legislation and changes in practice.

Progress on repeal and replacement of the MHA

In June 2020, the International Monitoring Mechanism (IMM) of the Convention on the Rights of Persons with Disabilities – Aotearoa New Zealand reported reported that overall progress is too slow in this area (Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities).

Having been appointed as kaitiaki (guardians) to provide independent scrutiny of progress and advice on the mahi (work) to transform the mental health and wellbeing system through implementation of the recommendations of He Ara Oranga, the Initial Mental Health and Wellbeing Commission (2020) provided an early check-in on progress. With a back-drop of Aotearoa New Zealand continuing to have high rates of compulsion and seclusion, the milestones and work in progress on recommendation 34 of He Ara Oranga had seen Cabinet agree on the following principles for the repeal and replacement of the Act: Human rights approach; maximum independence, inclusion in society and safety of individuals, their whānau and the community; alignment with the principles of Te Tiriti o Waitangi; improved equity of care and treatment; recovery approach to care and treatment; timely service access and choice; provision of least restrictive mental health care, respect for family and whānau.

In addition, the Guidelines for the Mental Health (Compulsory Assessment and Treatment) Act 1992 were also being reviewed to address issues identified through both He Ara Oranga, as well as ones identified in the mental health and human rights assessment conducted by the Ministry of Health in 2017, as part of the 2014-2018 Disability Action Plan.

It was also reported that, in relation to recommendation 35, the Ministry of Health had indicated that targeted discussions with some key stakeholder representatives were underway, and more was planned in this space.

From the people they spoke to it was reported that they heard:

- *"genuine hope for a rights-based system with more accountability, underpinned by the repeal and replacement of the Mental Health Act"* (p. 29)
- *"The need to improve how the new legislation would affect Māori"* (p. 29)
- *"People [reiterate] that new legislation won't itself be transformative—it must be supported by other changes"* (p. 29)
- *'Support for a partnership approach to designing new legislation: For new legislation to meet the needs of Aotearoa New Zealand, it is important that the people most affected by the current Mental Health Act have opportunities to provide input into the design of the new Act"* (p. 31).

However, it was reported that those on the front-line had communicated that "*they did not feel like they were an ongoing partner in the process"* (p. 31).

With respect to 'the Guidelines' work, the Office of the Director of Mental Health and Addiction Services published two documents, designed to work together, the MHA revised guidelines (Ministry of Health, 2020) and a "companion guide" (Ministry of Health, 2020a). The guidelines refer to the 2019 report from the Waitangi Tribunal (Waitangi Tribunal, 2019) which stated key principles interpreted from Te Tiriti o Waitangi, for application in primary health care of partnership, active protection, equity, and options. The "companion guide" can be understood as providing guidance as to how *"the principles of Te Tiriti o Waitangi,* *supported decision-making and 'least restrictive' care and treatment should be applied under the Mental Health Act"* (p. vii). However, a particularly concerning section of the "companion guide" reads:

> *Compulsory treatment does not mean that people lose their human rights … To avoid unnecessarily infringing on people's human rights, they should provide compulsory treatment in a manner that is consistent with the NZBORA, the Code of Rights and Te Tiriti o Waitangi principles to the greatest extent possible, and in the least restrictive way.* (p. 7)

This appears to show a lack of understanding and appreciation for the conclusions of the international and domestic reviews that have been undertaken and concluded that compulsory treatment is fundamentally and absolutely inconsistent with International human rights conventions that New Zealand has signed and ratified.

The Government also introduced the Mental Health (Compulsory Assessment and Treatment) Amendment Bill in March, which was passed in October 2021. The Act eliminates indefinite treatment orders by requiring the Courts to review an order at the end of each 12-month period for the duration of the compulsory treatment order. Arguably this is more of a procedural response to the issue of indefinite treatment orders as opposed to anything substantive. In any event, the amendment comes into effect by Order of Council, or 24 months after the Act has received royal assent. Its' application is, therefore, likely to be some months away.

The Ministry of Health sought feedback on He Ara Oranga report's recommendations from a coalition of lived experience and whānau leaders. Balance and Wellbeing Coalition Aotearoa (2019) identified the recommendations did not go far enough to end forced treatment. The recommendation to repeal and replace the 1992 Act, for example, entails wording to minimise coercion, not abolish it absolutely. Overall, the coalition stated coercive treatment *"violates the sovereignty of the mind"* (Balance Aotearoa and Wellbeing Coalition Aotearoa, 2019, p. 3). In addition, the coalition stated the report included nothing about advocacy, peer advocacy, and holding accountable complaints processes involving the district inspectors and Mental Health Review Tribunal. In Mā Te Rongo Ake / Through Listening and Hearing (2021) - the next progress report of the Initial Mental Health and Wellbeing Commission - it was reported that the *"[p]eople we spoke to expressed significant concern as well as cynicism around the short-term reform work"* (p. 105). The following quote was used to exemplify this opinion particularly from the lived experience perspective:

> *Because fundamentally it comes down to how are you ever going to incorporate Te Tiriti o Waitangi into what we're doing if you're fundamentally removing te rangatiratanga from people under the [Mental Health] Act. It really comes down to that. If that's going to continue to happen then the alignment is never going to be complete.* (Lived Experience voice) (p. 105)

A thematic analysis of the interviews undertaken to inform the Initial Mental Health and Wellbeing Commission's interim progress report on the Government's priorities in response to He Ara Oranga identified the following themes in relation to the recommendations concerning the MHA:

- *"Māori organisations and representatives from government recognised the importance of taking a focus on equity and partnering with Māori when undertaking work to repeal and replace the MH Act, particularly given the disproportionate rates of Māori sectioned under the MH Act"* (p. 80)
- *"clear communication [on the repeal and replace process] was considered an important part of achieving public buy-in"* (p. 80)
- *"…for lived experience communities, it was important that the MH Act is addressed from a blank slate, rather than amending the Act as it currently stands"* (p. 81)
- *"This approach was considered important in order to build new legislation based on Treaty principles and tino rangatiratanga (self-determination)"* (p. 81)
- *"Intentions for new legislation to be built on the following principles were noted: te Tiriti o Waitangi, taking a Human Rights approach, enabling maximum independence for individuals and inclusion of people in society, a recovery approach to care and treatment, timely access to services, least restrictive care, respect for whānau (taking a community focus not individualistic focus)"* (p. 81)
- *"a shift from a risk-based approach, to one that takes a human rights and safety focus"* (p. 82)
- *"the need for the mental health and wellbeing system to be appropriately structured and resourced in a way that supports [appropriate use of the MHA]"* (p. 83)
- *"Particular concerns were raised by Māori, consumer advocates and government departments around the disproportionate use of the MH Act and compulsory treatment orders (CTOs) on Māori, and the need to address issues such as the culture and inequitable practices surrounding CTO use"* (p. 83)
- *"Māori organisations and whānau groups in particular highlighted the challenges that people face in receiving the care and support that they need, and how the MH Act is viewed by some as a means of accessing the system"* (p. 84)
- *"Improving access to services and treatment, such as reducing the cost barriers to medication, was considered an important step for reducing the inappropriate use of the MH Act and CTOs"* (p. 84)
- *More needs to be done to reduce seclusion practices (note: detail associated with this theme is not reported here)* (p. 85)

Whilst looking to international examples of MHA repeal, it was reiterated that *"any new legislation will need to reflect a Māori world view"* (p. 82).

In terms of full repeal and replacement of the MHA, in November 2021 the Ministry of Health issued a consultation paper on Transforming our Mental Health Law: A public consultation document with submissions due in January 2022. A document summary of written and oral submission themes Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions was prepared for the Ministry of Health and released by the Ministry in May 2022. The Ministry of Health is currently developing policy advice for Government on what should be included in new mental health legislation. The consultation paper indicates the very beginning of a reform process, which is likely to take several years. In light of this context, we describe next how we have interpreted the project scope.

A review of literature on perspectives of compulsory treatment

The focus of our search was **primary qualitative peer-reviewed research and grey literature** that included participants who identified as, tāngata whaiora – people seeking wellbeing when experiencing mental distress or whānau, hapū, iwi, family or significant others who support people experiencing mental distress. We also sought to prioritise eligible literature that included service-user involvement in leading or co-leading research design, process and knowledge, with a focus particularly on Māori and Pasifika. It also included whānau or family who may be using family support within services.

Aotearoa: limited research and scholarly works

In this section we provide an overview of peer reviewed published research and scholarly works in Aotearoa that were identified as primary qualitative studies involving tāngata whaiora / people seeking wellbeing when experiencing mental distress (see document Appendix B for more information about the method and Appendix E for more information about studies in this review).

Peer reviewed research publications

There are no recent studies, that is, in over a decade. Only four (n=4) publications from seven were included after application of our criteria for primary qualitative research. All four publications (2004-2010) emanate from the Otago Community Treatment Order (CTO) Study. This was an interview-based study that was undertaken in Aotearoa during the early 2000s. Despite the age of these four studies, they represent a contribution to highlight CTO use in practice. However, these studies had limitations at the time, which have become even more significant. The research aimed to explore the views of patients with recent experience of CTOs; 42 patients in one region under an order in the last 2 years, not readmitted to hospital for at least 6 months.

Important to the context of the Otago CTO Study is that it was conducted at the time jurisdictions elsewhere (Wales) were looking to introduce CTOs and broader international inquiries were being undertaken into the clinical efficacy of CTOs, especially to reduce hospital readmission rates (Churchill et al 2007). Aotearoa was a world leader in implementing CTOs. Project team member Giles Newton-Howes commented that the CTO scheme was new and shaped by use, no one knew what to expect but all hoped it would prevent the revolving door. The social, political and medicolegal contexts are all now very different, even though the MHA is largely the same. We consider these interview studies to have historical value. In Gibbs, A et al (2005) How patients in New Zealand view community treatment orders, the majority of patients were generally supportive of the community treatment order, if the alternative was hospital admission. The authors reported findings that the usefulness of community treatment orders was accepted by most of the studies' participant 'patients'. Critical factors include the quality of therapeutic relationships and the structure provided for community mental health care. Of three additional publications from the study, one focuses on Maōri participants' experiences (Gibbs, 2004), another on women's experience of being under a community treatment order (Gibbs 2010). A third publication focuses on the experiences of family (Mullen, 2006).

From the perspective of contemporary best practice approaches to this kind of research these studies have limitations.

- This broader CTO Study can be viewed as a precursor to the complexity of relations between 'stakeholders' and multiple views on compulsory treatment (e.g.CTOs). We noted another publication on factors influencing mental health practitioners' decisions to use CTO via a survey of psychiatrists is not within scope of this review.
- While these publications are the first to explore 'patient' and family perspectives, basic methodological approaches are a limitation. For example, responses that CTOs were favoured over worse alternatives – homelessness and forensic facility – suggests other options were not explored with participants. Ambivalence among patients' views on CTO experience was also not explored in the analysis. Access to service was reported as a benefit of a CTO, rather than a condition.
- Contrary to contemporary perspectives – qualitative methods were applied without any reported examination of underpinning worldviews, reflexivity or considering structures of oppression embedded in the mental health system which can be a limitation to making sense of perspectives (e.g. missing critical, socio-historical analysis of power in systems of professional and cultural knowledge that are embedded or invisible in the organisation and funding of services). For example, it is possible that when people experience coercion or fear within the system that researchers are often seen as being part of the system too. So people may be fearful to say if they do not agree with CTOs.
- There is no engagement with Te Tiriti o Waitangi principles reported. The imposition of the medical model by Māori mental health workers does not reflect the holistic worldview of Māori.
- No tāngata whaiora were involved in the production of the research. At the time of the study co-produced research was embryonic, and non-existent in this space.

However, our analysis serves to highlight considerations for similar future studies to be in-step with contemporary critical and Indigenous qualitative research approaches.

Doctoral and Masters Theses scholarly works

Thesis and masters research below includes five doctoral works, four of which focused on Māori experience, and one masters' thesis focused on Samoan experience. However, a literature search limited to peer-reviewed published research would not yield any of these scholarly works, which are grey literature.

The thesis research identified uncovers and increases understanding of complexity in cultural perspectives on experiences of compulsory treatment (also compared to publications, thesis research is less constrained by word limitations). More in-depth analysis is achieved through the studies adopting a range or combination of different philosophical positions about knowledge from which to explore perspectives, including analyses of social, cultural and professional constructions of power operating in the mental health system.

Several kaupapa Māori studies have amplified the strong link and focus on relationship building (whakawhanaungatanga) which is seen both positively in how it supports wellbeing, and negatively in lack of appropriate engagement that is meaningful for tāngata whaiora and whānau (Baker 2017, Eade 2014, Wharewera-Mika 2012). Findings generated from a study focused on an inpatient acute unit endorse the need for more comprehensive care planning based on Te Whare Tapa Whā to better support tāngata whairoa (Eade 2014). In another study centred on inpatient services, recommendations included improving access to kaupapa Māori services; and enhancing practices that support whakaoranga and whānau ora, such as balancing safety and restriction; reducing the negative impact of police involvement; accessible supports for tāngata whaiora and whānau; increased implementation of kaupapa Māori therapeutic interventions; development and implementation of debriefing and reflective practices following critical incidents; and ensuring collaborative discharge meetings for all tāngata whaiora (Wharewera-Mika 2012).

These three studies combined highlight focus on outcome evaluations of inpatient services assessing whether the needs of Māori are being met. Implications of this research is on the efficacy of seclusion, restraint, and use of force with a focus on reducing and eventually eliminating these restrictive care practices.

Another PhD thesis focused on mental health crisis intervention involving service users, families, nurses and the police (Wilson, 2014). Findings highlight the complexity and dominant use of language (discourses) in use of force and lack of community crisis options. Service users, families, nurses and the police bear disproportionate amounts of responsibility during a mental health crisis in which they are held accountable for much of what occurs in the clinical and community setting.

Samoan conceptions of mental health, particularly the role of language in compulsory psychiatric treatment, was the topic of a Masters' thesis *Samoan Perceptions of the Mental Health Act* (Leasi, 2016). The results of the study suggest community CTOs used disproportionately more often with Samoan patients than in the general population, and that Samoan patients have very little understanding of the implications of these orders. Themes of lack of knowledge among the patients, and ambivalence and power among staff, were prominent. The findings of the study indicate a need for greater research about the use of compulsory psychiatric treatment and further investigation into Pasifika conceptions of mental health, particularly the role of language.

These critical and Indigenous accounts relate to some of the problems and solutions presented in the submissions and findings from some of the international studies reviewed for this report. The next examples of 'grey literature' focus on voices of Māori and Pasifika lived experience of compulsory treatment.

Lived experience of compulsory treatment Māori and Pasifika voices

The former Mental Health Commission published an education series titled *Pacific people in New Zealand talk about their experiences with mental illness* (Malo 2000). In a section of the publication participants spoke about their experience of coercive practices and breaches of rights.

> *'I've been locked up and fed up with drugs. I nearly died of overdose from being drugged up there.' Some of the interviewees felt that the measures of safety in services hindered their freedom. … One of the consumers spoke of how medication had been forced upon him while in an acute ward, while he was an informal patient, which brings about the issue of the breach of the code of rights. …Many consumers are admitted to hospitals, then discharged without ever being given the opportunity to know their rights. The services need to alert every consumer to the fact that, even under a Community Treatment Order, they do have rights. The posters of the code of rights in English often exclude those Pacific Islanders who struggle with the English language.* (Malo, 2000, p. 24)

The above extract emphasises access to information about rights as a barrier to enabling rights in practice and the research above suggests little has changed over 15 years (Leasi, 2016). Further research that focuses on Pasifika experience of compulsory treatment must be a priority.

In 2015 Baker released *He Kai I Nga Rangatira He Korero O Nga Whānau Whaiora NGO Advocacy Report*. The foundation for the report was a one day hui in Auckland, where people with lived experience of receiving mental health services attended to share their thoughts of being subject to the mental health act and of acute mental health care. The hui encouraged shared discussions with key reflections, aspirations and insights.

> *The core themes identified by the participants of being under the mental health act, included not understanding the compulsory assessment and treatment process, and experiencing the converse to mental health professional advice on what was going to occur under the act. Some viewed the act as a bargaining tool to get out of the mental health unit quicker, others viewed the act as providing a false sense of security for access to medication with significant implications to livelihoods after being in acute care, with examples of overt discrimination. Lastly, participants identified the struggle to being released from the Mental Health Act.* (Baker, 2013, p. 5)

The above core themes highlight the detrimental impacts on lives and distrust of mental health professionals as a result of coercive practices. Of particular significance is how participants describe the 'struggle' to be released from MHA – which increasing numbers of MHA use since 2005 would affirm (data on MHA rates noted earlier in section 2.1 of our report). The experience participants spoke of also reinforces the earlier call of Elder and Tapsell (2013) for urgent research led by Māori.

Overall, our search yielded very little service-user/patient primary qualitative research and no service-user led, or co-created research was found in the category of Aotearoa New

Zealand peer-reviewed publications. Importantly, the lack of indigenous/Māori led studies is qualitatively significant because of the ways data are collected and analysed when it is not a kaupapa Māori research approach being utilised. For example, the scholarly works highlight the ways research using critical and kaupapa Māori approaches reframe the problem of compulsory treatment and generate solutions. Additionally, examples of grey literature show that inquiry led by Māori and Pasifika lived experience cultural contexts enable access to more critical views on the effects of compulsory treatment experience by those most impacted by it.

Aotearoa New Zealand tāngata whaiora voices: Lived experience of compulsory treatment in submissions on transforming our Mental Health Law public consultation 2021

In this section we first describe our collection of 13 submissions to the Ministry of Health on repeal and replacement of the Mental Health Act 1992 (MHA). As described earlier in our report, since 2019 the Ministry of Health has been working on immediate and short-term improvements under the current MHA. Alongside this work, between 22 October 2021 and 28 January 2022 the Ministry of Health conducted public consultation on the repeal and replacement of the MHA. *Transforming our Mental Health Law A public consultation document* 2021 invited response to questions on specific topics in parts 3-9 under the following headings:

3, Embedding Te Tiriti o Waitangi and addressing Māori cultural needs; 4, Defining the purpose of mental health legislation; 5, Capacity and decision-making; 6, Supporting people to make decisions; 7, Seclusion, restraint and other restrictive practices; 8, Addressing specific population group needs; 9, Protecting and monitoring people's rights.

The submissions we reviewed correspond to parts 3-9 of the Ministry of Health consultation document and often use the same terms of language. The topic of 'compulsory treatment' potentially relates to all parts of the consultation document, in particular parts 5 and 6. Part 7 is outside the scope of our review insofar as it relates specifically to seclusion and restraint, and we have not focused on this content in any of the submissions. All submissions we collected are from different types of organisations that advocate for the interests of tāngata whaiora.

Table 2 below identifies each of the 13 submission documents by organisation name and shows the type of organisation by checked characteristics. Ten submissions are from national organisations that support and advocate for members/people with lived/living experience of mental distress seeking wellness, two of these are regional organisations. One submission is representative of an international peer network. Of the national organisations, two are commissions (independent crown entities), and one is a provider. One regional organisation and one national organisation are Māori-led, the leadership is Māori and they are guided by tikanga Māori in their approach.

We set out a description of each of 13 submissions in a separate document, Appendix E. As an overall summary of the submissions, we noted each organisation included a brief description of its purpose and aim, for example a preamble 'who we are' or an origin story as a way to position and frame their advocacy on behalf of tāngata whaiora. Submissions featured tāngata whaiora quoted extracts as examples of the 'voices' of experience and in some cases described lived experience comments specific to experience of the MHA. Submissions also varied in presentation style and method. For example, not all submissions included comment on the process to obtain views, and numbers of those involved. Submissions included a mix of high-level discussion of principles, with reference to Te Tiriti o Waitangi and international human rights. Some documents included references to published local and international research literature in support of their submissions. The documents ranged in length between 2 pages and 44 pages.

Table 2 Submission documents – organisation and advocacy

Document #	Organisation	National	Regional	Government (Commission, Public health)	Non-government (Charitable Trust)	Service provider (peer support, consultation)	Māori Led	Lived experience led
1	Changing Minds	●			●			●
2	Mind and Body	●				●		●
3	Global Mental Health Peer Network	●						●
4	Te Kete Pounamu	●			●		●	●
5	Take Notice	●					●	●
6	Ngā Hau e Whā	●						●
7	Awareness [Canterbury]		●					●
8	Thriving Madly		●					●
9	Otago Mental Health Support Trust		●					●
10	National Association of Mental Health Consumer Advisors	●		●				●
11	Mental Health Foundation	●			●			
12	Health and Quality Safety Commission	●		●				
13	Mental Health and Wellbeing Comission	●		●				

The next part of this section is based on our close reading of the submissions. (See Appendix

B for more information about framing analysis and our project approach). We apply framing analysis research questions to the contents of each submission document with a focus on extracts that describe the problems and the solutions. In this process we considered how compulsory treatment was described (framed) as a problem (who is affected, the causal roots) and what was advocated as a solution. For our analysis below, we synthesise content from these submissions to outline areas of consensus and difference. We aim to depict a collective tāngata whaiora voice whilst at the same time we aim to illustrate how submissions were differently shaped by advocacy, in particular by and for Māori.

Areas of consensus and difference

A lot is shared across submitters in terms of the 'problems' and 'solutions'. The problems relate to the structure and services in the mental health system generally, and are mostly specific to compulsory treatment. All submissions advocate for an expanded range of support and treatment service and delivery options for/by tāngata whaiora. For example, one submission advocates for the abolishment of compulsory community treatment orders as such orders would not be necessary where adequate services and appropriate treatment and care options were in place.

A strong message across all submissions is that system and service transformation must occur now and alongside policy to guide the new law. In relation to solutions, we noted that submission documents all advocate for changes to practice, service structure, organisation, and workforce that are required to make positive change in addition to new law that minimises compulsory treatment or eventually eliminates compulsory treatment, for example over a period of years.

All submissions advocate for inclusion of Te Tiriti. To inform their submission, the Mental Health Foundation (MHF) heard from 14 participants, the majority of whom whakapapa Māori, and reported themes of the hui in a document for the purpose of informing the MHF Submission (Mental Health Foundation, 2022). The hui involved tāngata whaiora participants that had recent or current experience of the Mental Health Act, including one person on a long-term treatment order. The MHF also heard from two whānau members at a dedicated session for whānau. A kaupapa Māori approach was followed in the running of the hui, with appropriate tikanga and the opportunity to wānanga. This created a safe space that honoured the kōrero shared by hui participants.

The MHF report outlines the main themes from the hui, which describe the values any new mental health law should uphold. Tāngata whaiora also clearly felt the Mental Health Act should only be used as a last resort, if at all, as reflected in the words of this hui participant.

> *For me, I don't like legislation at all. And as long as we have it around, **it will always be restrictive**.* (Mental Health Foundation, 2022, p. 5).

The over-arching message the MHF heard was that new mental health legislation, and the sector, should be grounded in te ao Māori and that to achieve this, solutions need to be led by tāngata whaiora Māori. This means hiring Māori with knowledge of tikanga Māori and mātauranga Māori into the mental health workforce, and supporting tāngata whaiora Māori and their whānau in a safe, kind and culturally responsive way. From the kōrero, MHF identified the following five sub-themes to illustrate the values that hui participants feel should be reflected in any new mental health legislation, and across the sector:

1. **Tino rangatiratanga**: for tāngata whaiora over their healing journey.
2. **Manaakitanga**: towards tāngata whaiora and their whānau.
3. **Whanaungatanga**: to create meaningful relationships between tāngata whaiora, their whānau and the mental health system.
4. **Wairuatanga**: to ensure a holistic model of health is adhered to.
5. **Whānau**: to ensure whānau are adequately supported so they can provide meaningful support for tāngata whaiora. (Mental Health Foundation , 2022, p. 5).

Several submissions included aspirational visions of what a new MHA must include to help ensure transformational change beyond the mental health sector to the whole of society, in which all people live their best lives through connected communities. All submissions advocated supported decision-making – which sometimes read as support (resources and people) to make decisions alongside retaining limited compulsory treatment in a new law. However, as described earlier in our report, guidance from the Committee on compliance with the CRPD is that any form of compulsory treatment that is substituted decision making is inconsistent with supported decision making.

Key areas of consensus on solutions (alternatives) to compulsory treatment included more options for safe places to stay (not just hospital) when in severe distress – more choice and better access to holistic treatment options, especially kaupapa Māori services and treatment. Holistic care came through very strongly, in particular culturally informed approaches to care. Peer workforce and acute alternatives also were strongly present in some submissions as well. Some submissions advocated for mandated access to treatment, peer support, cultural support, as a way for new legislation to help ensure access available for tāngata whaiora to choose options other than medical approaches. Other 'legal' solutions related to access to treatment in crisis included mandated Advance Directives.

A key areas of difference seemed to be whether a) to eliminate compulsory treatment absolutely in new law; or b) to retain but minimise compulsory treatment in new law; or c) to retain but reduce compulsory treatment towards its minimisation and /or elimination, for example over period of years. In terms of those proposing retaining some form and degree of compulsory treatment, most advocated for an increase in legal safeguards to provide protections for tāngata whaiora rights and upholding tino rangatiratanga, including a separate Māori authority with oversight to audit compulsory treatment use. In addition, submissions advocated increased, independent service monitoring to enforce reducing/ minimising use of compulsory treatment.

Whilst there was some difference, the majority of submissions submit that some form and extent of compulsory treatment should remain. It would appear that people are wanting a 'back stop' – so, for example, the submissions would seemingly be fully supportive of supported decision-making however most of them had a 'but'. The other way that this can be interpreted is that most submitters had an aspirational approach – 'in an ideal world, then yes; but given the pragmatics, then no'. Furthermore, there is not a lot of detail as to what alternatives would consist of. The issue here is that our current system and services would not support transformational legislative change and so, it is difficult to envisage such. That is why the point made through He Ara Oranga and the Initial Mental Health and Wellbeing Commission is absolutely key - new legislation won't itself be transformative - it must be supported by changes in practice. People also need to appreciate and be able to trust that with an appropriate change in practice the abolishment of substitute decision-making should never equate to an abandonment of support. If some form of substitute decision-making regime were to remain there are a couple of potential issues: (i) Aotearoa will still not be compliant with the International Convention on the Rights of Persons with Disabilities; (ii) it is possible that an exception to allow substitute decision-making within an overarching supported decision-making framework would become the default.

The recommendations from He Ara Oranga were arguably interdependent – e.g. people needed to engage in the national discussion to reconsider beliefs, evidence and attitudes about mental health and risk prior to embarking on their involvement in the repeal and replace process. However, to engage in such a discussion, people need to be informed – for example, to be aware of the relevant international and national law that challenges the legitimacy of compulsory treatment, key evidence-base related to compulsory treatment, what is known about use its use in practice in Aotearoa; and most especially, to hear the voices of those who have experienced compulsory treatment. This work goes some way to enabling that informed position however what we have found has also highlighted the lack of tāngata whaiora voices and focus being privileged. Unless actions are taken now to address this then we will be yet again repeating a process and generating an outcome that does not work with and for the people most affected.

Interestingly Māori were more likely to advocate for complete abolishment so whilst all submissions advocated for more recognition of Te Tiriti o Waitangi in mental health law and practice, Māori were more able to articulate how this might be applied in practice and serve to be transformational. This highlights the importance of all repeal and replace work involving a partnership with Māori, including tāngata whaiora, any new legislation needing to reflect a Māori world view and for the necessary changes in practice to be particularly considered from this perspective.

International results: our summary of qualitative research studies on compulsory treatment

Our overview of international peer-reviewed research publications is organised in three groups, according to the participant stakeholders involved: service users, family, and multiple stakeholder combinations of service users, family and/or mental health professionals. In the studies with multiple stakeholder participants, we only included those that separated out the different perspectives in their analysis and findings. For each group of studies we identify author names and country and provide a brief description in a separate Appendix G.

For the purpose of this section on International peer reviewed publications we present a summary here as an overview and critical reflection. This section brings together in one place all services user perspectives, all family perspectives, all mental health perspectives across all studies reviewed to enable summary discussion. We adapted our approach to analysis of the submissions to apply the framing analysis problems and solutions questions to critically appraise the research studies in this review. Overall, the studies reviewed find shortfalls between participants' actual experience and what is meant to happen in practice, including satisfying professional, service, policy and legal requirements. The implications of the findings often result in recommendations for ways in which those experiences of compulsory treatment might be improved, rather than avoiding its use.

Service user perspectives

We organise the following 17 studies involving service user participants in relation to those that focus on experiences of compulsory assessment/inpatient hospitalisation, followed by studies on compulsory community treatment. A third set of studies is related to both hospital and compulsory community treatment.

Compulsory assessment process/inpatient hospitalisation (n=8)

In these studies, compulsory treatment is raised as a problem in the context of the importance of therapeutic relationships in the access and provision of acute mental health services. Involuntary hospital admission and treatment can undermine therapeutic relationships and exacerbate a 'daunting and frightening experience'. Some studies characterise compulsory treatment as a power imbalance between patients and staff and focus on a lack of information or choice in patient experience. A particular relational focus is on understanding 'negative' language to make sense of experiences of compulsory treatment; people's views on the clinical decision to compulsorily detain them. Generally, the scope of problems are communication and information that lead to analyses focused on how to make the experience of compulsory treatment a better one for patients, rather than how to avoid compulsory treatment altogether. As a result, the solutions presented through these studies' findings are aimed at more staff reflection, education, training: staff listening to service user concerns; service users having a space to make sense of their experiences; staff ability to look beyond service user illness and diagnosis; and staff working in partnership. Another finding is that patients' experiences of compulsory treatment can form the basis for preparing an 'individual action plan' for future compulsory treatment. The implication is that individual action plans could empower patients during compulsory treatment and improve their experience of care.

Compulsory community treatment (n=5)

In these studies the problem of compulsory community treatment was excessive restriction and control. This was often only compared to an alternative of involuntary inpatient admission – also a form of compulsory treatment. Compulsory treatment in the community was better able to be tolerated or was experienced less negatively by participants, provided that they received other services that they found beneficial which were accessed under compulsory community treatment. Additionally, therapeutic relationships between care providers and patients are of importance to how patients interpret providers' behaviour and the restrictive interventions (although this might also be read that the feeling of being coerced is open to interpretation, whereby experiences are invalidated as misinterpreting intent due to level of un-wellness). Solutions presented in findings included access to support, empathetic, respectful clinicians and safe practices so as to minimise trauma, and maximise autonomy and freedom in planning to empower the individual. These studies also acknowledged the above 'paradoxes' in compulsory community treatment and urged ongoing reflection and discussion about those paradoxes, a discussion that must involve service-users.

Unspecified and/or both inpatient and outpatient compulsory treatment (n=4)

Highlighted in these studies is the problem of navigating a mental health 'system' where distress appeared rooted in social structures that disadvantage people. For example structures that embed racism and disadvantage black people. Psychiatry and police involvement appeared to be experienced as a further form of oppression, that initially provoked resistance and fear, and over time, resignation to the identity of psychiatric patient. The problem is that legislative change is insufficient to change the dominant psychiatric paradigm. The implications are fundamental shifts are required in practice in therapeutic relationships, and holistic and recovery perspectives. Another problem of ongoing compulsory treatment is the implication that a 'failure to exit the services' is the person's fault rather than the fault of systemic barriers, and in particular with ethnic minorities, inadequate cultural responses.

These studies also focus on understanding in practice the 'negative' language to make sense of experiences of compulsory treatment with the implied aim being to use these understandings to influence and shift practice to make it seem less coercive. A related problem is participants' complaints being dismissed due to 'lack of insight'. In the example of one study 'minor incidents' that were experienced by participants as coercive, such as being 'defined' by the medical model, receiving repeated negative remarks and 'feeling one needed to succumb to get care' are major issues in findings. The implications of findings are effects of being defined by a diagnosis and the treatment that follows is not a 'minor incident' of coercion especially if people feel they need to succumb (indicates coercion) to agree with something that fundamentally goes against their values in order to get the support they may need.

Solutions presented by these studies emphasise the need for 'talking therapies' and 'protection of social roles' – community, social and familial, inclusive of family in support, - in order to keep people connected. Other solutions involve understanding mental distress related to trauma and the importance of people reconnecting or connecting to cultural identity. Solutions for improving the process of compulsion, included legislative reform and fundamental shifts in practice in terms of the nature of therapeutic relationships, and in embracing more holistic and recovery perspectives.

Family perspectives

A small number of publications (n=5) focus solely on family perspectives' on compulsory treatment - three on experiences during involuntary hospital admission and two on experience during compulsory out-patient treatment. All studies seemed to frame the problem as little attention, in literature, to the range and variety of family experiences as being important for understanding what happens in mental health services in practice. This limited knowledge is important to address where there are extensive and detailed legal requirements concerning involvement of family during involuntary hospital treatment of 'seriously mentally ill patients'. Similarly there are policy and practice standards that emphasise the importance of engaging and supporting families of people with mental health problems in treatment and care planning, such as in acute inpatient units and in the community treatment order process. The studies find the role of family in a myriad of wellbeing support roles are insufficiently recognised and enabled in mental health services and mental health law. Lack of family involvement is a barrier to improve 'patient' care and wellbeing. Solutions involve changes in staff practices and mental health service processes centred on more open and continuous communication with family. A solution of 'imposing care' should be an option available to family was a finding in one of the studies.

Multiple perspectives of service-users, family and practitioners

This small set of studies (n=15) involved research participants from one or more of the identified 'stakeholder' perspectives. We organised the studies in three sub-groups based on participant stakeholders in each study. Only two studies involved service-user and family (n=2). The next group of studies involved service user and family and mental health practitioners (n=5), and the third group included service users and mental health practitioners (n=8). We included only studies that separated different perspectives under stakeholder headings below. The summaries of the individual studies under each group are described in a separate Appendix G. In the international publications we reviewed terms such as service users, consumers, patients, and family and carer are used, where 'carer' does not refer to a paid mental health professional or practitioner.

Service user and family perspectives (n=2)

The importance of unique context is amplified by these studies; variability and complexity in relations between service-user and family perspectives feature strongly. In these studies, service-users' non-compliance with compulsory treatment was framed as an individual problem in that the focus was on service-users' not taking medication as required. The focus of treatment was medication. A related and underlying problem was that of exclusion of service-users and family from collaborative decision making with mental health practitioners about treatment. This exclusion compounded service-users' and families struggle to negotiate acceptable and effective routes through variable quality of care.

Service user, family and mental health practitioner/provider perspectives (n=5)

In these multiple key stakeholder studies, compulsory treatment is framed more as a clinical tool of intervention. Although an Australian study examines power in structures and service bias, finding that clinicians striving to work collaboratively with service users had to navigate a service bias and culture that emphasised a hierarchy of 'knowing', with service users' assumed to have less knowledge than clinicians.

Understood as a clinical intervention, studies characterise compulsory treatment as beneficial in terms of providing stability, safety, and access to resources/support as compared to no compulsory treatment. The problems of compulsory treatment are associated with access to clinical services and the pathways for clinical treatment. For example, a finding is that community CTOs are preferred by service-users over involuntary hospitalisation.

Problems of compulsory treatment in practice were also framed as individuals' non-adherence to treatment medication or non-compliance with treatment in which the individual behaviour is the focus, rather than treatment options underlying 'non-compliance' which is a punitive term.

These studies also highlighted the paradox of personalisation under compulsion by exploring the problem of how person-centred care can be better incorporated into the making of CTOs. Reflecting on an apparent contradiction 'person centred' is directed and decided by the person, if a CTO gives agency to a service it is not person centred. An associated problem is that service users were often inadequately informed about compulsory treatment and their legal rights.

Solutions include improvements in procedural justice, for example to inform patients of their existing rights. Other solutions are to incorporate 'recovery' models or practice in use of CTOs – despite acknowledged tension, or conflicting frames of paternalism and self-determination. For example, services and clinicians can challenge prejudicial ethical injustice and counter this through testimonial justice and implementation of tools and approaches that support genuine shared decision-making.

Service user and mental health practitioner/provider perspectives (n=8)

Research publications in this sub-group involved participants from Australia, Canada, and Norway. Most of the research (n=5) focuses on compulsory treatment in the context of community, as opposed to inpatient settings, although the 'path' from community to inpatient characterises one of the studies from Norway. The mental health practitioner stakeholders are primarily from the clinical discipline and practice of nursing, and this appears to influence the focus of research problems, on inter-relations, trust, therapeutic relationships, especially in admissions/inpatient studies.

A key focus of these studies is that trustworthy relationships are fundamental to the experience of benefit or not of compulsory treatment. The problem is compulsory treatment undermines trustworthy relationships; trust or mistrust play an import role in whether or not service users found compulsory treatment beneficial. Overall, problems are not how to reduce compulsory treatment, but how to make it a better experience for patients, such as in combination with a solution of access to assertive/intensive treatment in community teams. Solutions include a focus on changes to mental health practitioner behaviour and ways of working. For example, where compulsory treatment effect is to make work of staff harder so solution is to 'alleviate burden of management of compulsory treatment on nurses'. Studies also highlight the role and function of language; ways compulsory treatment use/experience is described by practitioners and service users. Solutions are offered, through exploration of metaphors to encourage more understanding of how to promote autonomy, capacity and supported decision-making, and how to address the impacts of mandated coercion within care.

To summarise, in our review the international peer reviewed publications of 'stakeholder' studies, strikingly, did not privilege lived experience voice. Our search yielded no service user-led or Indigenous-led research in the production of knowledge about compulsory treatment, despite inclusion of studies from Australia and Canada. The studies we reviewed highlight problems consistent with more critical approaches to ongoing compulsory treatment. The solutions are oriented toward improvement of existing practices, directed toward practitioners and service providers. Taken together, these are important and worthwhile contributions to deepen our understanding of compulsory treatment in practice –this is because the global scope of psychiatry and law enables a level of comparison between countries where compulsory treatment is embedded in their mental health system. However, our review reveals a research problem – there is a paucity of lived experience and Indigenous knowledge, despite the growing social visibility of lived experience 'voice' of mental illness/distress. Framing the problems of compulsory treatment in research must attend to challenging questions and extend beyond investigations of how to make compulsory more palatable to investigations into how to abolish substitute decision making as is consistent with legal obligations in international human rights (CRPD). Future research into compulsory treatment must include diverse bases of knowledge to yield the most innovative solutions, for practical application in a local context where people seek to live their everyday lives well.

Pathway forward

This whakatauki encourages people to have vision, and to strive to achieve their vision:

Ko te pae tawhiti, whaia kia tata, ko te pae tata, whakamaua kia tina.

Seek out the distant horizons, and holdfast to those you attain.

Summary

Drawing on our summaries of Aotearoa research together with the sections on International research, our main finding is that there is little to no peer-review published qualitative literature - of stakeholder perspectives on compulsory treatment that had a focus on tāngata whaiora, people seeking wellbeing when experiencing mental distress, particularly Māori and Pasifika - that would contribute to enabling advocacy to uphold the mana and rights of tāngata whaiora in the context of the current process of repealing and replacing the Aotearoa mental health legislation.

The international research summaries show at a very general level how 'problems' and 'solutions' related to compulsory treatment can be framed in limiting ways in the absence of lived experience and Indigenous knowledge. Additionally, the publications we reviewed were not undertaken against a background of potential transformation of mental health law – unlike the current context for Aotearoa. For these reasons, the research questions or problems with compulsory treatment focus on how to improve ways in which compulsory treatment, care, services are provided with the aim of making the experience of coercion better for those who are made the subjects of compulsory treatment, rather than how to eliminate compulsory treatment altogether (as in no-force advocacy).

We found little international research in applied public health and services space drawing on critical social science and/or Indigenous and service user led/co-led research in practice which is somewhat unusual given the growth of these areas of research.

We hence emphasised grey literature through a small number of scholarly works that have made a significant contribution using kaupapa Māori approaches and critical social theory to amplify voices absent or not well presented in mainstream research. Most of these works are Indigenous/Māori, Pasifika and/or tāngata whaiora led studies and are qualitatively different because of ways data is collected and analysed. They enable access to the reframing of views on what are primarily the negative effects of compulsory treatment experienced by those most impacted by it and, in some cases, generate proposed solutions. This includes the strong link and focus on relationship building (whakawhanaungatanga) which is seen both positively in how it supports wellbeing, and negatively in lack of appropriate engagement that is meaningful for tāngata whaiora and whānau. The issue here however is that a literature search limited to peer-reviewed published research would not yield any of these works.

Evidence to influence and inform new policy to transform MHA in Aotearoa must draw on the voices of tāngata whaiora, people seeking wellbeing when experiencing mental distress, particularly Māori and Pasifika. Hence new research is urgently needed to deepen our understanding of the way tāngata whaiora frame the 'problems' and the 'solutions' that might be generated when considering the reform of mental health legislation. This should particularly include Māori-, Pasifika- and tāngata whaiora-led research involving Indigenous and critical qualitative methodologies.

We also extended the project to consider the broader context for mental health law and system transformation in Aotearoa New Zealand, encompassing a review of key information and documents of pertinence, to tell a story in terms of tāngata whaiora voices and focus more generally. Drawing the historical lines together paints a picture of growing recognition of Māori and non-Māori first-hand lived experience voices and focus and we have emphasised these to the greatest extent possible throughout this section. We framed the story as tracing a pathway to where we stand.

Since 2005, compulsory treatment rates have increased both absolutely and as a proportion of population numbers, and New Zealand's use of community treatment orders is amongst the highest in the world. The disparities in these rates faced by Māori are extreme, and the call for urgent Māori-led research into disparity rates between Māori and non-Māori has not yet resulted in any in-depth inquiry or examination that could provide critical insights into what sits behind these disparities and the resulting impact of them. Internationally research studies based on aggregate data reveal there is insufficient evidence that compulsory community treatment orders re effective, with the conclusion of such studies being that given the lack of evidence, compulsory community treatment should not be used.

When investigated in more depth, tāngata whaiora expressions of ambivalence and/or a preference for compulsory treatment are often about the ability to access services. Despite a system that may be stretched, compulsory treatment should never be used as a mechanism to support access to treatment. The caveat that respect for rights are subject to a maximum of available resources, as applies to economic, social and cultural rights, does not apply to human rights categorised as civil and political rights as are those that are breached by compulsory treatment.

Since the Convention on the Rights of People with Disabilities (CRPD) came into force international human rights law has been interpreted as requiring the abolishment of substitute decision-making regimes, and the introduction of supported decision-making. The Aotearoa MHA is variously criticised for enabling and the rates of use of compulsory detention, compulsory treatment, and seclusion; and the disparities faced by Māori. United Nations bodies have recommended Aotearoa New Zealand to take all necessary legislative, administrative and judicial measures to rectify the situation, often with the specification that attendance to such should be immediate.

He Ara Oranga generated two recommendations in relation to the MHA: Repeal and replace the MHA (recommendation 34) and Encourage [stakeholders] to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk (recommendation 35). The Government accepted and prioritised these two recommendations relating to the MHA. He Ara Oranga and responses to that have identified that new legislation won't itself be transformative—it must be supported by changes in practice.

The process for full repeal and replacement has commenced with the public consultation. We drew on lived experience voices presented and represented in in the form of 13 selected submissions to the Ministry of Health on its public consultation document transforming the MHA. Key areas of consensus from the submissions included that system and service transformation must occur now/alongside policy to guide new law; that there must be more recognition of Te Tiriti o Waitangi in mental health law and practice; and that supported decision-making must replace substituted decision-making. Key areas of difference were that compulsory treatment should be removed absolutely from new law; that elimination should occur through a process of reduction over a period of time 5-10 years; that the use of compulsory treatment should be backed-up by stronger independent monitoring by new/existing bodies – for Māori, for seclusion/solitary confinement. Solutions for policy options included: more options for safe places to stay (not just hospital) when in severe distress; more choice and better access to holistic treatment options, especially kaupapa Māori services and treatments; more workforce development roles and leadership that recognise tāngata whaiora lived experience voice, especially of compulsory treatment.

Despite there being difference between absolute abolishment and some retention, the majority of submissions did advocate that some form and extent of compulsory treatment should remain. The issue here is that our current system and services would not support transformational legislative change and hence, it is difficult to envisage such.

Interestingly Māori were more likely to advocate for complete abolishment so whilst all submissions advocated for more recognition of Te Tiriti o Waitangi in mental health law and practice, Māori were more able to articulate how this might be applied in practice and serve to be transformational. This highlights the importance of all repeal and replace work involving a partnership with Māori, including tāngata whaiora, any new legislation needing to reflect a Māori world view and for the necessary changes in practice to be particularly considered from this perspective.

The recommendations from He Ara Oranga were arguably interdependent – e.g. people needed to engage in the national discussion to reconsider beliefs, evidence and attitudes about mental health and risk prior to embarking on their involvement in the repeal and replace process. However, to engage in such a discussion, people need to be informed – for example, to be aware of the relevant international and national law that challenges the legitimacy of compulsory treatment, key evidence-base related to compulsory treatment, what is known about use its use in practice in Aotearoa; and most especially, to hear the voices of those who have experienced compulsory treatment. This work goes some way to enabling that informed position however what we have found has also highlighted the lack of tāngata whaiora voices and focus being privileged. Unless actions are taken now to address this then we will be yet again repeating a process and generating an outcome that does not work with and for the people most affected.

Directions for advocacy

Suggestions **to further advocate for the rights of tāngata whaiora and solutions for change** that follow from our review reflect that recommendation 35 from the He Ara Oranga report has not translated into meaningful action and needs to in order that we can proceed with MHA reform in an informed manner. In the first instance, we must focus on action: ***to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk***. People need to be informed in order to engage in this discussion.

- **Toward all tāngata whaiora advocacy groups**: Call to a hui 'general assembly' between groups to discuss a shared advocacy agenda on beliefs, evidence and attitudes about compulsory treatment and what replacement supported-decision making would look like in practice, when, where and for who.
    - Focus on our (tāngata whaiora) voice in the first instance. We can also advocate for others to be informed and particularly the general public but we need to think about how that should be done
    - Start with a vision – do we want revolution (no compulsory treatment) or evolution (some degree of compulsory treatment that lessens over-time). We need to be clear about what we might be saying either-way and what the consequences of this may be. What is the vision for us to uphold the mana and rights of tāngata whaiora in the context of the current process of repealing and replacing the Aotearoa mental health legislation.
    - Agree shared values – decide on values and keep on coming back to them in terms of decision-making and advocacy

  We suggest this as a way forward for collective interests to focus on three interconnected areas in which to develop key messages that we want to be heard 'strong and clear' amongst other voices of interest groups speaking about mental health and risk. Where possible we have made connections to literature reviewed.

    - Calling attention to the language of compulsory treatment experiences and terminology. Australian studies highlight the role and function of language to perpetuate beliefs, evidence and attitudes about mental health and risk (e.g. metaphor – unpacking ways in which compulsory treatment use/experience is described by service users and mental health practitioners). Our team reflected that this must include cultural safety and be clear it is not a translation of medico-legal terms. For example, the right to choose treatment options is also about worldview/understanding, approaches, ways of being, and language.

    - Challenging beliefs about beneficial effects of compulsory treatment (individual and society) based on research evidence, particularly focused on effectiveness of compulsory community treatment orders - *a Community Treatment Order is a legal status not a therapeutic intervention*
    - Describing the alternatives to compulsory treatment – what they need to be

    and what they are (those that exist already). The solutions described in this review might be drawn on as a way to identify the kinds of things that can be and must be done now, in readiness for a new law - the abolishment of substitute decision-making does not equate to the abandonment of support

- **Toward sector leaders, professional colleges of psychiatry and nursing, NZ police, mental health lawyers, Judges, district inspectors, mental health services leadership of general and service managers and clinical leaders:** There is potential to build alliances within and across these groups in relation to shaping policy solutions. These groups apply powers of compulsory treatment and review and monitor its use.
    - What do these groups of people need to know and do to enable our vision?
    - What alliances are important?
- **Toward policy makers**: Advocate our collective vision and values and what these mean in practice. Lobby to be kept informed on progress. Highlight the importance of all repeal and replace work involving a partnership with Māori, including tāngata whaiora, any new legislation needing to reflect a Māori world view and for the necessary changes in practice to be particularly considered from this perspective.
    - Advocate based on that fact that new legislation won't itself be transformative—it must be supported by changes in practice – this is so important
    - Know how the system, and practice specifically, needs to be different in order to enable your vision for transformation. This means working through the possible intended (and unintended) consequences of legislative change on the ground – such as in the practical implementation of 'rights'.
- **Toward actively seeking opportunities for influencing broader sector and public perceptions and/by enabling tāngata whairoa to lead discussion about compulsory treatment.** For example, through forums of community events, social media, radio, online and print publications. Audiences should include mental health service providers and community providers of social support and accommodation. To Nōku te Ao Like Minds: we recommend the consideration of initiatives that target attitudes about mental health and risk.
- **Toward research funders**: Little research exists about experience of compulsory treatment in Aotearoa and we must prioritise tāngata whaiora-, people seeking wellbeing when experiencing mental distress, including Māori and Pasifika particularly, led research on this subject. This would mean advocating to research funders for resource and support to be provided for tāngata whaiora to be able to undertake such research in a way where we are able to pursue investigations based on what is important to us and what we believe are essential criteria for research questions, design, methodology and production of knowledge. This review report could help inform key research questions that have not yet been answered and should be prioritised.

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