Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Compulsory treatment should be absolutely minimised across mental health settings

Position statement

August 2024

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The use of compulsory treatment should be absolutely minimised in mental health settings across Aotearoa.[1]

Policy & Advocacy
August 2024

The Mental Health Foundation of New Zealand (MHF) advocates for the new mental health law and accompanying system, service and practice changes to absolutely minimise compulsory treatment in our mental health system over the course of ten years, with immediate action to minimise its use significantly.

A move to a less coercive system must be facilitated by service and practice changes across the mental health and addiction system to ensure tāngata whaiora, whānau and health workers are appropriately supported and kept safe.

These changes should be led and informed by those with lived and living experience of the Mental Health Act, including tāngata whaiora Māori.

What is compulsory treatment?

Someone may be treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) if they experience an 'abnormal state of mind' and, due to this, are deemed to be unable to take care of themselves or pose a risk to themselves or others. The Act can be used to provide mental health treatment, whether or not they agree to it.

After a period of assessment by a mental health clinician, a judge may decide to place the person under a compulsory treatment order. A compulsory treatment order is a court order stating that a person who is assessed as having a 'mental disorder' must receive treatment for up to six months. This is often known as being 'sectioned' or 'admitted' under the Act.

There are two types of compulsory treatment orders:

[1] At the time of writing, the Labour-led government has published its policy decisions for a new mental health law and a new Bill is being drafted.

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1. **Community treatment orders,** where tāngata whaiora live in the community, for example at home or in supported accommodation, and are treated in the community, such as at a community mental health service.

2. **Inpatient orders,** where tāngata whaiora stay in a mental health ward of a hospital for treatment, although they can be given leave at times.

Compulsory treatment in Aotearoa New Zealand

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... (Schneller, et al., 2022)

The number of people on compulsory treatment orders in Aotearoa has been increasing over the years – particularly the use of community treatment orders (Manatū Hauora - Ministry of Health, 2023). As a snapshot, on 30 June 2022, **a total of 5,975 people** were subject to either compulsory assessment or treatment under the Act (Manatū Hauora - Ministry of Health, 2023). This is an increase from 5,645 on that same day in 2021 (Manatū Hauora - Ministry of Health, 2022). On an average day in the year between 1 July 2021 and 30 June 2022:

- 4,900 people were on a community treatment order.
- 763 people were under an inpatient treatment order.
- 176 people were on temporary leave from an inpatient unit.[2]

During that year, clinicians made 6,097 applications for compulsory treatment orders or extensions under the Act, and of these applications, 5,377 (88 percent) were granted by the courts (Manatū Hauora - Ministry of Health, 2023).

[2] These are all increases from an average day in the previous year, according to the Office of the Director of Mental Health and Addiction Services Regulatory Report 1 July 2020 to 30 June 2021 (Manatū Hauora - Ministry of Health, 2022).

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Certain groups are more likely to be subject to compulsory treatment orders:

- Tāne Māori are the most likely to be subject to community and inpatient treatment orders.
- People aged between 24 and 35 years are the most likely age group to be subject to compulsory treatment.
- Māori are 4.0 times more likely than non-Māori and non-Pacific peoples to be subject to community treatment orders, and 3.6 times more likely to be subject to inpatient treatment orders.
- Those living in the most deprived areas of Aotearoa are more likely to be subject to compulsory treatment orders. Among tāngata whaiora under community treatment orders in 2021/22, 46 percent of Māori and 45 percent of Pacific peoples were living in the most deprived areas of Aotearoa, compared with 27 percent of non-Māori and non-Pacific peoples (Manatū Hauora - Ministry of Health, 2023).

MHF position

The use of compulsory treatment (and other restrictive practices) is only considered necessary because most people cannot imagine a response to mental health that is well resourced and fully integrated across prevention and wellbeing promotion and with comprehensive, recovery-based services and supports across a wide range of settings. In short, Aotearoa New Zealand has failed to imagine a humane, effective and healing system and therefore continues to endorse and perpetuate a harmful, inhumane and ineffective one.

Aotearoa New Zealand's new mental health law should absolutely minimise compulsory treatment over the course of ten years, so it is ultimately only used in the rarest of circumstances. Setting a legal time limit will act as a lever to force system, service, workforce and practice change and investment in staff and facilities now, not later.

Our position accepts there may be a small number of cases where the use of compulsory treatment might be necessary for a short period of time, for example for

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a person's safety or where someone experiences serious impairment of decision-making ability and, after exploring all options, it is not possible to establish their will and preferences. However, this should only occur within a system that upholds strict regulation and scrutiny of these cases to ensure any restrictions on a person's rights are absolutely necessary, applied in the least restrictive manner and for the shortest time possible. Community compulsory treatment must be targeted only to those most likely to benefit, such as people with psychosis (Beaglehole, Newton-Howes, & Frampton, 2021).

The new law must use Te Tiriti o Waitangi as its foundation and directly reference Te Tiriti o Waitangi preamble and articles: kāwanatanga, rangatiratanga, ōritetanga and wairuatanga. This should be achieved by creating the new legislation in partnership with Māori.

Minimising compulsory treatment does not mean reducing access to acute services, but rather providing the full suite of services to respond to Aotearoa New Zealand's mental health need without regular compulsion to access these services.

This means resourcing and supporting services to provide effective community based, person-centred, culturally safe, trauma-informed care, that reflects and upholds Te Tiriti o Waitangi and our human rights obligations. This means investing in services that provide care and support to people earlier, in their homes and communities and with staffing levels and clinical practices that enable cultural and peer support and perspectives, connection to culture and identify, and approaches based on holistic models of care including those grounded in te ao Māori and Pacific ways of healing. It is our view, and that of others, that if the systems response is done well, special provisions for compulsion can be reduced to the barest of minimums in law and practice (Douglas, Young, & McMillan, 2020).

Rationale

The MHF's position is supported by the following arguments:

1. The evidence on whether compulsory treatment results in positive outcomes for tāngata whaiora is mixed, and this should be weighed against lived experience evidence that compulsory treatment can result in significant harms for tāngata whaiora, their whānau and healthcare workers.

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2. New Zealand's use of community compulsory treatment in particular is unjustifiably high (by international standards) and rising, despite evidence it is only effective under very limited circumstances.

3. The disproportionate use of compulsory treatment on tāngata whaiora Māori breaches Te Tiriti o Waitangi and the United Nations Declaration of the Rights of Indigenous Peoples.

4. The high rate of compulsory treatment in Aotearoa breaches the United Nations Convention on the Rights of Persons with Disabilities.

5. There are practice and system changes we can make in our mental health system that will reduce reliance on compulsory mental health treatment.

6. There are already examples of community-based mental health care approaches in Aotearoa that do not rely on compulsory treatment.

There is mixed evidence on the effectiveness of compulsory treatment in mental health settings.

Some studies found positive impacts of compulsory treatment, particularly for tāngata whaiora who are at a higher risk in the immediate term and for those who experience psychotic disorders.

Internationally and domestically, there are studies that show benefits in both inpatient and community compulsory treatment for mental health. These benefits include reductions in the frequency and length of admissions and the dispensing of psychiatric medication, as well as more opportunities for clinicians to identify and manage comorbid physical illnesses and monitor the adverse effects of medications (Van Kranenburg, et al., 2022; Stuen, Landheim, Rugkasa, & Wynn, 2018; Beaglehole, Newton-Howes, & Frampton, 2021; Kisely, et al., 2013). Some studies highlight the positive benefits from the point of view of tāngata whaiora, such as access to services, increased sense of security and safety (including for whānau), and improved understanding of their mental distress or illness (University of Otago Faculty of Law; Gibbs, Dawson, Ansley, & Mullen, 2005; Dawson & Mullen, 2008). It is unclear, however, whether these positive benefits are from the access to treatment itself, or its involuntary nature (Kisely, Campbell, & O'Reilly, 2017; Burns & Dawson, 2009).

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Compulsory treatment can be particularly effective in the short term, by addressing and reducing immediate risks to someone's health and safety, such as for those who are at heightened suicidal risk, or for severe eating disorders (Segal, 2022; MacDonald, Gustafsson, & Bulik, 2023; Tury, Szalai, & Szumska, 2019; Giacco & Priebe, 2016; Suetani, Foo, & Wilson, 2014). The benefits of compulsory treatment are also found to be greater for those who experience psychotic disorders (such as schizophrenia) (Beaglehole, Newton-Howes, & Frampton, 2021; Kisely, et al., 2013; O'Reilly, Dawson, & Burns, 2012; Giacco & Priebe, 2016).

There are some studies that found zero benefit, or negative impacts from compulsory treatment.

Some research found zero to little benefit from compulsory treatment, with marginal differences in readmission, access to specialist care, social functioning or symptomology compared with standard care (Dey, Mellsop, Obertova, & Jenkins, 2022; Kisely, McMahon, & Siskind, 2023; Tseng, et al., 2022; Scarpa, Grahn, & Lundgren, 2023; Rugkasa, Yeeles, Koshiaris, & Burns, 2016). Other studies found involuntary treatment added to the unhappiness and distress of tāngata whaiora, causing further harm (Tseris, Bright Hart, & Franks, 2022; Newton-Howes, 2013; Light, et al., 2015; Beaglehole & Tennant, 2023). Other studies found mixed and inconclusive results about the impacts of compulsory treatment (Beaglehole & Tennant, 2023; Nyttingnes, Benth, & Hofstad, 2023).

Tāngata whaiora and their whānau have shared with the MHF evidence of the harms caused by compulsory treatment.

Tāngata whaiora the MHF spoke with described their experiences under compulsory treatment as traumatising and dehumanising, stripping them of their tino rangatiratanga and autonomy, and harmful to their recovery and healing.

> *"The Mental Health Act is a place of fear."* (Participant at tāngata whaiora hui, 2021)

> *"I was just so afraid and so frightened… and they didn't reduce the fear they kind of fuelled the fear… You feel almost like a criminal when they take you in if you've just had a manic episode. You're treated like a flippin' criminal and that's not fair because we're not, we are just sick."* (Participant at tāngata whaiora hui, 2021)

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"[compulsory treatment is] a fancy way of saying we're going to take away all of your human legal rights now and you'll have no choice about what goes into your body or what gets done to your body and we'll dictate what your life's going to look like…we've moved forward enough in time to see the negative effects of it being OK which is a higher mortality rate and over representation in so many areas… and the evidence tells us it's not working so why keep doing what doesn't work…the only way to recovery with and for people is acknowledging that they actually have a right about what goes into their body, the impact of that and what they want their lives to look like using a holistic approach and model of care and I don't think that's going to happen in the medical system because we've already proven it doesn't work…so it's going to need something really new and innovative…." (Participant at tāngata whaiora hui, 2021)

While some tāngata whaiora report benefits from compulsory treatment, these benefits are often associated with increased contact with services, rather than the compulsion itself.

A literature review into tāngata whaiora views and experiences of compulsory treatment concluded that tāngata whaiora "ambivalence and/or a preference for compulsory treatment" is often about the ability to access care and treatment (Schneller, et al., 2022).

Perverse incentives exist that reinforce a system of compulsory treatment. These include better access to medical care, free medication (Baker, 2015) and even the structure and social interaction that community treatment orders provide for tāngata whaiora with chronic mental illness who may be lonely and on the margins of society (Newton-Howes & Ryan, 2017). Tāngata whaiora spoke to the MHF about compulsory treatment orders 'opening doors' to more options such as medications compared with voluntary psychiatric care.

"I think the difference between being voluntary and…being under compulsion because, when you're there voluntary, you know, you're there to seek the service, you're trying to get well, you're trying to find that wellness and get back to life and… the way that

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service is structured is there's certain things they can't do until you are under compulsion so some of the medications or treatment plan considerations that they go into… that door doesn't unlock until you go under compulsion… it gives them more options."
(Participant at tāngata whaiora hui, 2021)

New Zealand's use of community compulsory treatment in particular is unjustifiably high (by international standards) and rising, despite evidence it is only effective under very limited circumstances.

There is little evidence that community treatment orders provide a therapeutic benefit outside of the benefits associated with increased contact with services (Beaglehole, Newton-Howes, & Frampton, 2021). An umbrella review of data examining the benefits and harms of community treatment orders in several countries showed the more rigorous studies tended to find mixed or no effect on reducing frequency and length of inpatient admissions or improvements to other clinical, psychosocial or forensic outcomes, except when targeted towards people most likely to benefit, such as those experiencing psychotic disorders (Kisely, Zirnsak, Corderoy, Brophy, & Ryan, 2024).

Aotearoa New Zealand has a high and increasing rate of community treatment order use compared to other jurisdictions (O'Brien, 2014), and as with all forms of compulsory treatment, community treatment orders are used on tāngata whaiora Māori at a greater rate and for longer durations (Manatū Hauora - Ministry of Health, 2023). About 75 percent of tāngata whaiora under a compulsory treatment order are under a community treatment order (Manatū Hauora - Ministry of Health, 2023).

While community treatment can offer tāngata whaiora more physical freedom than inpatient care, community treatment orders are typically active for much longer than inpatient orders, with most lasting over two years (and many, until recently,[3] applying indefinitely) (Manatū Hauora - Ministry of Health, 2023). Tāngata whaiora have spoken about how hard it can be to be relinquished from a community treatment order (Te Hiringa Mahara - Mental Health and Wellbeing Commission,

[3] Indefinite compulsory treatment orders were eliminated on 29 October 2023, in accordance with the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021.

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2023). Their high rate of use, and typically prolonged duration, has raised the question of whether compulsory community treatment has resulted in a net reduction of coercive mental health care since its introduction in 1992, or has simply relocated the primary site of coercion from psychiatric institutions to communities (O'Brien & Kydd, 2013).

Tāngata whaiora and whānau have said that they perceive ongoing mental health support and treatment to depend on the continuation of a community treatment order and that discharge from a community treatment order means tāngata whaiora will no longer be eligible for support (Te Hiringa Mahara - Mental Health and Wellbeing Commission, 2023). It appears that community treatment orders have become a major vehicle for securing tāngata whaiora access to necessary mental health care, while paradoxically limiting the potential for recovery by creating barriers to building trusting, collaborative relationships between tāngata whaiora and services (Te Hiringa Mahara - Mental Health and Wellbeing Commission, 2023).

The disproportionate use of compulsory treatment orders for Māori is a breach of Te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).

The disproportionate rates at which Māori experience compulsory treatment[4] in Aotearoa breach Te Tiriti o Waitangi and our obligations under the UNDRIP.[5] These inequitable outcomes show that our mental health system legitimises unconscious bias and institutional racism towards Māori (Government Inquiry into Mental Health and Addiction, 2018), as well as removing their ability to legally exercise tino rangatiratanga or autonomy.

The significant disparity between Māori and non-Māori in regard to compulsory treatment actively harms Māori health outcomes, shows there is clear discrimination in our mental health sector towards Māori, and does not reflect, uplift or value

[4] From 1 July 2021 to 30 June 2022, Māori were 4.0 times more likely than non-Māori and non-Pacific peoples to be subject to community treatment orders, and 3.6 times more likely to be subject to inpatient treatment orders (Manatū Hauora - Ministry of Health, 2023).
[5] The UNDRIP sets out individual and collective rights of indigenous peoples, including the right to identity and the right to health, prohibits discrimination against indigenous people, and promotes their full participation in all matters that concern them and their visions of economic and social development.

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mātauranga ways of healing, or wairuatanga in healing approaches used. In order to remedy these breaches and eliminate the inequities related to compulsory treatment, the mental health and addiction system transformation must be explicitly grounded in Te Tiriti o Waitangi (Te Hiringa Mahara - Mental Health and Wellbeing Commission, 2022).

Compulsory treatment breaches our international obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

Article 12 of the CRPD states that legal capacity – the right to make decisions about oneself – is a fundamental and inherent right afforded to all people, including those with disabilities (United Nations, 2006). Equality before the law is a basic principle of human rights protection and is indispensable for the exercise of other human rights. Therefore, people with disabilities have legal capacity on an equal basis with others, and an individual cannot lose their legal capacity simply because of a disability. Rather, all people have legal standing and legal agency simply by virtue of being human (Committee on the Rights of Persons with Disabilities, 2014). Article 12 of the Convention makes it clear that a disability by way of an 'abnormal state of mind'[6] is not a legitimate reason to deny legal capacity.

Other key CRPD articles that are breached by compulsory treatment in Aotearoa New Zealand include:

- The freedom to make your own choices (Article 3A).
- The right to be free and safe and not deprived of freedom arbitrarily (Article 14).
- Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16).
- The right of people with disabilities to be treated as a person on an equal basis with others (Article 17).
- The right to good health and health services on the basis of free and informed consent (Article 25).

[6] Part of the definition of 'mental disorder' under the Mental Health Act.

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There are practice and system changes we can make in our mental health system that will reduce reliance on compulsory mental health care.

Evidence shows services that are designed and funded in alignment with the following features can keep people safe and allow them to heal, without coercion: culturally safe; person-centred and rights-based; community-based; employ supported decision-making and advance directives; trauma-informed; include families, whānau and fanau; offer peer support and medication alternatives; and form a support network with education, housing, employment and social protection services (World Health Organization, 2021).

See also:

- Our letter on multi-agency approaches to mental health crises.
- Our position statement on supported decision-making.
- Our report summarising tāngata whaiora and whānau perspectives on tino rangatiratanga and decision-making under the Mental Health Act.

Multi-agency approaches to mental health crises and supported decision-making have both been proven to reduce the use of compulsory treatment.

There are already examples of community-based care approaches in Aotearoa that do not rely on compulsion.

We advocate for growth in national coverage and long-term funding for services that do not rely on compulsion, such as:

- Rapua Te Āhuru Mōwai: A kaupapa Māori mental health service pilot which provides affordable, high-quality rental housing to tāngata whaiora in Tāmaki Makaurau. It operates as a collaborative partnership between Te Toka Tumai clinical services, CORT (community housing provider) and Mahitahi Trust to provide wrap-around support to people who would otherwise have nowhere to go after being discharged from an inpatient mental health unit. They have seen a reduction in readmission rates and, where readmissions do occur, longer periods of time between them.

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- Kōtukutuku Papakāinga in Ōtara, Auckland: This community accommodation is run by a community housing provider for those with living experience of mental distress. It is made up of 40 single-bed units, a whānau apartment for family members to visit, and a Whare Manaaki, a gathering place for hui and celebrations where tenants come together as whānau. Tenants are able to access wellbeing support services if they need or want them, and the papakāinga uses peer support. It is a home, a refuge, and a house of healing, and is grounded in kaupapa Māori.

- Hāpai Mauri Tangata crisis response team in Whanganui: Hāpai Mauri Tangata is an initiative between Māori health provider Te Oranganui Trust, mental health charitable trust Balance Whanganui, the police, and the regional health service. It deploys seven-person crisis response teams including mental health and alcohol and drug clinicians, a family violence key worker, peer support worker and cultural support person, to help people experiencing mental health crises. This model seeks to respond to people with compassion and without police, unless necessary, and to reduce admissions to inpatient services. Although this is a new initiative and has not yet completed an evaluation of its impact, evidence shows that crisis response units such as this can reduce admissions to compulsory care (see our letter on alternative approaches to mental health crises (linked above) for citations).

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