

“What does [a different system] look like? I would be the captain of my own ship.”

Submission from the Mental Health Foundation of New Zealand to the Ministry of Health’s consultation on transforming mental health laws in Aotearoa

January 2022



Executive summary

**Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora
He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora
Hinengaro**

The Mental Health Foundation of New Zealand (MHF) supports the repeal and replace of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

Our submission draws on 45 years of analysis, advocacy and interaction within the mental health system and is directly informed by hui with tāngata whai ora (those with lived experience of being subject to the MHA) and their whānau held in 2021. Tāngata whai ora told us the current MHA enables traumatising and dehumanising practices that do not support their recovery, and they want change. The system is geared towards heavy medicalisation and coercive behaviour to encourage compliance, and it creates incentives that reinforce compulsion rather than self-determination because being subject to the MHA enables greater access to care and free medication (see Part 1).

We recognise the commitment of clinical and support staff to providing care every day in the face of significant workload and resourcing pressures and the progress being made to reduce restrictive practices across DHBs. We acknowledge the Government's significant investment into primary and secondary mental health support and its commitment to transforming mental health law.

The MHF considers a well-resourced response to mental health that integrates appropriate social conditions/prevention, strengthens wellbeing in the community and provides enough resources for a full range of mental health and addictions services would almost completely eliminate the need for restrictive practices. The rights of all New Zealanders demand this response is created.

We see a residual role for compulsory treatment and restraint in a handful of situations. The number of instances where this would be justified is so small that it would effectively be eliminating these practices.

The development of a new mental health law for Aotearoa is a once in a generation opportunity to reframe our response to mental health. We need to 'put a stake in the ground' and all but end compulsory treatment and restraint, reducing these practices to the barest of minimums by a date no later than ten years from the new legislation passing into law. Seclusion practices should be prohibited completely and immediately under the new law.

We recommend the new law set an end date of 10 years to make compulsory treatment and the use of restraint illegal except under tightly defined and regulated circumstances, reducing these practices to the barest of minimums. We recommend the legislation end seclusion completely once the new law is enacted (building on the decade-long Zero Seclusion project and success of DHBs that have achieved zero seclusion at times).¹ 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. Without it, we have no confidence the changes tāngata whai ora are calling for in our approach to preventing and responding to mental distress will ever truly take effect (see Part 2, Section A and B).

The new law should set out a two-stage process over the next decade. First, as an interim step, the new law should support a higher threshold of entry to compulsory treatment and specify enhanced scrutiny of all compulsory treatment decisions, and frame restraint practices as a service failure and subjected to rigorous review and debrief. It must support autonomy through embedding a legal framework for the immediate enactment of supported decision-making available 24/7 and clarifying the validity of advance directives (see Section C). Second, from a specified date, these entry threshold regulations and scrutiny mechanisms should be further strengthened to the point where compulsory mental health treatment and restraint practices are extremely rare, tightly controlled and highly scrutinised.

The new law must use Te Tiriti o Waitangi as the foundation and directly reference Te Tiriti o Waitangi articles, and to ensure tino rangatiratanga in this respect we recommend a Māori rōpū be tasked with policy and legislative development alongside the Ministry of Health. It should provide a legal mandate for all tāngata whai ora Māori who come into contact with specialist mental health and addictions services to be offered access to support by Māori and ways to connect to Māori culture (see Section C). We will need serious traction on addressing racism in all its forms to prevent and reduce mental distress for whānau Māori, alongside changes to workforce and clinical practices that value and practise te ao Māori and normalise Māori as a way of being.

New Zealand is now in a position to ban seclusion because of more than a decade's deliberate work to change practices along with setting a target date for elimination. A similar programme of work is required to enable the absolute minimisation of

¹ <https://www.hqsc.govt.nz/news-and-events/news/4268>

compulsory treatment and restraint. The current use of practices that violate the human rights of tāngata whai ora is only considered necessary because most people cannot imagine a response to mental health need that is well resourced and fully integrated across prevention, wellbeing promotion and a comprehensive range of culturally responsive, recovery-based services in a wide range of settings. In short, Aotearoa New Zealand has failed to imagine a humane and effective system and therefore, endorses and perpetuates an inhumane and ineffective one.

The new legislation provides powerful levers to reconstruct our approach to supporting people with severe mental distress based on best practice, human rights and appropriate resourcing. This should be guided by the system transformation approach outlined in *He Ara Oranga* and the voices and stories that contributed to the report. Our moemoeā (pages 10 - 12) sets out what supports, care and services, rights and cultures are needed as preconditions for the absolute minimisation of compulsory treatment and restraint.

We appreciate *He Ara Oranga, Kia Manawanui Aotearoa* and the Ministry of Health's intention to 'shift the paradigm' of mental health in ways that align with our moemoeā. **We recommend the new law include a requirement for development and enactment of a plan to implement supported decision-making and the full range of key service development and practice changes that will enable the absolute minimisation of compulsory treatment and restraint over 10 years. This plan should be co-designed with tāngata whai ora and tāngata whenua.**

We recognise that anything less than the complete eradication of all forms of compulsion falls short of compliance with the Convention of the Rights of Persons with Disabilities (the Convention). We encourage the Ministry of Health to make policy recommendations to ministers for a new law that aligns as closely as possible with the Convention and with parallel changes to ensure the system can support a new legal framework.

Additional recommendations include:

- Police may have a role supporting clinical staff while responding to situations in the community where people are mentally distressed and where there is a risk of harm, but they must be supported with a health and peer response, and with training and checks and balances to ensure force is not used disproportionately (see Section D).
- Revisit recommendations from the 2010 Law Commission's report *Mental impairment decision-making and the insanity defence*, specifically the recommended move away from ministerial decision-making about the reclassification or discharge of a special patient or special care recipient (see Section E).

- Provide a legal mandate to address physical health inequities experienced by tāngata whai ora (see Section F).
- In consultation with population groups and their representative bodies, include explicit principles and rights in the legislation to ensure population groups receive appropriate and compassionate care and support and which recognise overlapping and interdependent experiences of discrimination or disadvantage (see Section G).
- Futureproof against the on-going impacts of COVID-19 by incorporating into law the Ministry of Health's guidance on the use of audio-visual technology in mental health assessment and examinations and monitoring and public reporting requirements about its use (see Section H).
- Legally mandate, where possible, service development and practice changes, including upholding mana-enhancing care as a guiding principle in the new law to protect and enhance tāngata whai ora mana and dignity (see Part 3, recommendation 10).

Mauri tū, mauri ora



Shaun Robinson

Chief Executive Officer

Summary of recommendations

Part 2: Recommendations for new legislation

Absolute minimisation of compulsory treatment and restraint (second stage)

Recommendation 1: Design legislation to absolutely minimise compulsory assessment and treatment and restraint no later than 10 years after the new legislation comes into effect, through a two-stage process. Stage one being interim steps to immediately significantly reduce compulsory treatment and restraint (recommendations 3a-3q), and stage two being the introduction of an additional layer of legal restrictions and scrutiny that come into force at the 10-year mark.

Elimination of seclusion (first stage)

Recommendation 2: Prohibit the use of seclusion practices in mental health units when the new law comes into force, sending a clear signal in advance of the legal change, and supported by resourcing and independent oversight.

Significant reduction of compulsory treatment and restraint (first stage)

Recommendation 3: Design new mental health legislation to reduce inequities and significantly reduce compulsion and restraint as an interim step towards the absolute minimisation of compulsory treatment and restraint.

Recommendation 3a: Legislation should frame the use of restraint practices within in-patient units as a service failure, with each incident triggering an external review and de-brief with the person, whānau, peers and clinicians. The review should explicitly examine racial and gender bias in decision-making and seek to determine what service and practice improvements and resource are needed to provide safe and effective alternatives.

Recommendation 3b: Introduce national guidelines for the consistent collecting and reporting of restraint use across DHBs and by service user demographics and make this information publicly available. Data should be collected on types of restraints, the absolute numbers of restrained people, how many times they were restrained and for how long, counts of restraint incidents and people restrained per day per 1 million population, and statistics on duration for each type of restraint.

Recommendation 3c: Annual review and publication of the effectiveness of implementing strategies (e.g., Six Core Strategies) on reducing restraint practices and its impact on injury and assault rates.

Recommendation 3d: Design legislation based on an indigenous model with Te Tiriti o Waitangi as the foundation, directly reference Te Tiriti o Waitangi articles and outline how the law will give effect to Te Tiriti o Waitangi, such as routine cultural assessments, protected access to support by Māori and ways to connect to Māori

culture, and reserve the right for Māori to review and make the final decision about applications for compulsory treatment for tāngata whai ora Māori.

Recommendation 3e: Authorise a Māori rōpū comprising at the very least lived experience, whānau and mental health specialists to develop the policy recommendations and write the drafting instructions for the new law alongside the Ministry of Health.

Recommendation 3f: Enshrine in law a supported decision-making framework in line with the Code of Health and Disability Services Consumers' Rights, emphasising the presumption that all tāngata whai ora can make their own decisions and have the right to access supported decision-making at all times, including after hours.

Recommendation 3g: Include a more active legal obligation for the engagement of whānau in all aspects of a person's involvement in the Act within the context of a supported decision-making framework, and provide dedicated support and tools for whānau to understand and engage with the Act and the mental health care and wellbeing of their loved one.

Recommendation 3h: Advance directives should be given a legal mandate in primary legislation to clarify their legal status and the new law should set out a framework for creating valid advance directives for mental health care.

Recommendation 3i: Secondary mental health services must have robust processes in place as part of admission to easily identify an existing advance directive.

Recommendation 3j: Set a high threshold for entry into compulsory treatment in legislation, including that it is the last resort, that treatment is the least restrictive option and will be effective in their recovery; and exclude 'risk to others' in the criteria.

Recommendation 3k: Any capacity-based approach should ensure a person's will and preferences, expressed either directly or previously, remain central to the decision-making process even if they experience impairment of decision-making skills.

Recommendation 3l: Assessments for compulsory treatment should be made by multi-disciplinary teams, not single clinicians, and in collaboration with the person, a peer support worker, cultural advisors and whānau.

Recommendation 3m: Establish shorter assessment periods and a shorter compulsory treatment order period, compared to the current system, with regular periods of review.

Recommendation 3n: Establish a specialist mental health court or tribunal (rather than the Family Court) with processes designed with tāngata whai ora at the centre,

and ensure all employees of courts and/or tribunals, including lawyers and judges, receive training in mental illness/distress, including communication skills, and racism, stigma and discrimination awareness.

Recommendation 3o: Consider specific legal protections to restrict the use of procedures such as ECT and medications with significant side-effects and long-term impacts.

Recommendation 3p: Establish a comprehensive advocacy framework in the law to strengthen access to independent legal and peer advocates for redress and support.

Recommendation 3q: The law should specify independent oversight mechanisms regarding its application, including annual reporting, and with monitoring and advocacy powers to recommend system changes.

Role of police

Recommendation 4: Increase capacity for a health-based crisis response and rapidly scale up successful local pilots of co-response arrangements where police are supported by peer and health responses.

Forensic mental health

Recommendation 5: Revisit recommendations from the 2010 Law Commission's report *Mental impairment decision-making and the insanity defence*, specifically move away from Ministerial decision-making about the reclassification or discharge of a special patient or special care recipient.

Physical health equity

Recommendation 6: Support parity of esteem principles in the new law to address physical health inequities experienced by tāngata whai ora.

Intersectionality and population groups

Recommendation 7: In consultation with population groups and their representative bodies, include explicit principles and rights in the legislation to ensure they receive appropriate and compassionate care and support that responds to their background, identity, culture and circumstances.

Pandemic futureproofing

Recommendation 8: The Ministry of Health's guidance to practitioners on the use of audio-visual technology in mental health assessment and examinations, and monitoring and public reporting requirements about its use, should be incorporated into the legislation.

Part 3: The absolute minimisation of compulsory treatment and restraint over 10 years in legislation must be supported by equal changes to systems and practices

Recommendation 9: Set a legal mandate for the development and enactment of a plan, co-designed with tāngata whai ora and tāngata whenua, to implement key service development and practice changes that will enable the absolute minimisation of compulsory treatment and restraint over 10 years. We recommend an explicit commitment to change, specific actions with milestones, and an accountable entity that can drive change over time.

Recommendation 10: Legally mandate, where possible, service development and practice changes, such as requiring cultural, peer and clinical partnerships, support for wairuatanga, and include mana-enhancing care as a guiding principle in the new law to protect and enhance tāngata whai ora mana and dignity.

Recommendation 11: Ensure the Government's Service and Systems Framework and the Mental Health and Addiction Annex to the Health Plan is designed to respond to and support the changes needed for the elimination of seclusion and the absolute minimisation of compulsory treatment and restraint, and done so alongside tāngata whai ora and tāngata whenua.

Recommendation 12: Implement the actions and approach outlined in *Kia Manawanui Aotearoa* with a strong focus on mental wellbeing prevention and promotion. We have previously called for a rolling action plan with clear accountabilities and developed by April 2022, to ensure *Kia Manawanui Aotearoa* is implemented in a concrete and transparent way.

Recommendation 13: Progress action on the *He Tapu te Oranga o ia tanaga Suicide Prevention Strategy and Action Plan* and continue dialogue with the suicide prevention and postvention sectors on the implications for suicide of any new policy direction for mental health laws.

Recommendation 14: Implement *He Ara Oranga* recommendation 35 to carry out a broad national discussion of mental health risk and safety. Law and system changes will be a radical shift for some members of the public and whānau and the journey towards absolute minimisation of compulsory treatment and restraint must be supported with a significant and sustained programme of work to change perceptions of mental 'illness' and distress, understanding of risk, safety, and 'dangerousness', and the culture of prejudice and discrimination against people with experience of mental illness.

Moemoeā/vision for systems and services to support the absolute minimisation of compulsory treatment in Aotearoa

People and whānau who experience severe mental distress want and need....

Rights	<ul style="list-style-type: none"> • to live well • to be celebrated for their wisdom and strength gained through adversity and their journey to recovery • to be presumed capable of making their own decisions • the right to decide, with or without their chosen support, at the time or in advance, on their own medical treatment
Mental health system	<ul style="list-style-type: none"> • leaders to actively address the legacy of colonisation and racism in the way mental health services and systems assess and treat Māori • to be leaders in the systems that impact their lives • an apology for past trauma, indignity and abuse in the mental health system, redress, and system changes so the cycle of trauma is broken.²
Prevention – determinants of mental wellbeing	<ul style="list-style-type: none"> • access to resources and live in healthy environments • to participate and contribute fully in their communities and reconnect with themselves, their whānau, without experiencing prejudice or discrimination.

² Te Aiotonga

<https://ndhadeliver.natlib.govt.nz/ArcAggregator/arcView/frameView/IE12126512/http://www.dia.govt.nz/Agency-Confidential-Forum-for-Former-In-Patients-of-Psychiatric-Hospitals-Index>

Phone: 09 623 4810 | www.mentalhealth.org.nz

<p>Equip communities, whānau and individuals to look after their mental wellbeing</p>	<ul style="list-style-type: none"> • communities that respond to distress in a compassionate, knowledgeable, non-judgemental way • skills, knowledge and tools proven to be effective at improving mental and emotional wellbeing and growing the capacity of individuals and whānau to respond well to life's problems
<p>Primary mental wellbeing support</p>	<ul style="list-style-type: none"> • access to free or well subsidised counselling and other early-intervention therapies and supports, including peer support • supports available in a variety of forms and settings e.g., schools, GPs, community organisations and digitally • more kaupapa Māori primary care support options and culturally responsive care, including inclusion of rongoā and tikanga and supported by a strong Māori workforce of GPs and psychologists etc. • access to good physical and mental health outcomes and care with joined up and integrated services – urgent referrals can be made between physical and mental health care, and between primary care and mental health care • free or heavily subsidised medication (i.e., not connected to compulsory care)
<p>Crisis prevention and support</p>	<ul style="list-style-type: none"> • to be met with a compassionate, non-judgmental and therapeutic and trauma-informed response • to be supported to access timely and intensive support • to be met with a health response, supported by the peer workforce, and social support
<p>secondary mental health services</p>	<p>Services that:</p> <ul style="list-style-type: none"> • are delivered in community settings and in people's homes • understand and respect individuals' support circles and identities, and how they are supported by and support others • are co-designed by people with lived experience and Māori • have opportunities to provide feedback and advice on the services that they use • have physical environments that support wellbeing and cultural safety e.g. wharenuī or whānau rooms and access to marae. • are joined up with employment, income and housing support • are joined up with specialist addictions services and support that provide safe and separate environments to support the needs of people experiencing substance use and addiction effects • respond with culturally competent practitioners, more Māori and Pasifika psychiatrists, and a strong peer workforce • are embedded in tikanga from the start and throughout a person's journey • have adequate, well-supported and stable mental health workforce with safe and supportive working conditions • eliminate seclusion and absolutely minimise the use of compulsory treatment and restraint practices • support transitioning within and between services and supports.

	<p>Access to treatments and models of care that:</p> <ul style="list-style-type: none"> • build therapeutic relationships based on trust, value, respect, understanding and compassion • respond to the will and preferences of people and whānau and uphold self-determination • keep people safe on an equal basis with people receiving other forms of healthcare support • support positive risktaking to support recovery • are appropriate, safe, effective and timely • provides choice and options including bi-cultural and holistic approaches that embrace many worldviews and foster connections to culture (e.g. te reo Māori, access to whenua and mātauranga Māori) • provides expertise to support spirituality/wairua alongside clinical practice. • is recovery oriented and trauma-informed • builds long-term life and health outcomes • provide wellbeing promotion and self-management support
<p>Criminal justice</p>	<ul style="list-style-type: none"> • people experiencing mental distress diverted from the justice system and prison • a therapeutic focus with support for recovery in a forensic setting.

Introduction

Thank you for the opportunity to provide feedback on transforming our mental health law.

The Mental Health Foundation (MHF) is wholly supportive of the recommendation in *He Ara Oranga*, and supported by *Kia Manawanui Aoteroa*, to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA) and recommendations for the new law to reflect a human rights-based approach, promote supported decision-making, align with recovery and wellbeing models of mental health and provide measures to minimise compulsory treatment.

We recommend adopting an evolutionary approach that sees new legislation set an end date of no more than 10-years to make compulsory treatment and restraint illegal, except under tightly defined and regulated circumstances. Seclusion practices should be prohibited completely and immediately under the new law. We make a number of recommendations to reduce compulsory treatment as in interim measure towards absolute minimisation.

This submission is informed by six hui held with tāngata whai ora (80% of whom whakapapa Māori) and whānau in November and December 2021. All participants had recent or current experience of the MHA including one on a long-term treatment order. We have used themes and quotes collected from these to inform our submission and we will send the Ministry a copy of our summary report when this is available. It is also informed by correspondence from people with lived experience the MHF engages with across several platforms, including a 2019 MHF hui with tāngata whai ora and Māori clinicians about problems with the MHA, and input from MHF kaimahi with lived experience, past and present.

We have divided the submission into three parts. Part 1 outlines key problems with the current law highlighted through our engagement work (note this is not a comprehensive list), Part 2 sets out recommendations for new legislation, and Part 3 discusses the parallel system changes that are necessary to significantly reduce, and ultimately, absolutely minimise, compulsory treatment and restraint.

Our submission distinguishes between different types of 'restrictive practices', including compulsory mental health assessment and treatment/compulsion, seclusion, and restraint (including chemical, environmental and physical). We outline distinct policy implications and recommendations for each of these.

Part 1: Problems with the current law

"The Mental Health Act is a place of fear"

Tāngata whai ora we spoke to talked about their experiences under the MHA as traumatising, dehumanising, with a power imbalance and not conducive to their recovery or healing.

"...you get this being treated like a naughty little child kind of attitude just like, "I'm not a child. OK, I'm really unwell right now and I'm not dumb, and being treated like [you are] dumb and like you don't know what you're doing."
(Participant at tāngata whai ora hui)

"Clinical services have heaps of power, we have no power." (Participant at tāngata whai ora hui)

"I was just so afraid and so frightened... and they didn't reduce the fear they kind of fueled 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 whai ora hui)

A strong theme from tāngata whai ora was the **lack of scrutiny and accountability** built into the system to regulate compulsion treatment decisions. Some talked about the risk-averse nature of the MHA and psychiatry and how it is reinforcing coercion. Some felt compulsory treatment decisions were made too readily and without enough information about the person.

"....if something goes wrong it's the psychiatrists that get dragged through the coals, right...they have to go to...court to speak to why did this person die....so that's why psychiatry's this very risk averse environment and so how do they manage that they put us into these very coercive environments and coerce us into conforming and so it's all about... them protecting their own profession really isn't it? So it's fine to say yip we want them to be accountable to us but at the moment they are accountable to the courts and there needs to be a kind of shift in the unaccountability somewhere that...helps challenge that risk averseness and make it more of an actually holistic approach to wellbeing...." (Participant at tāngata whai ora hui)

"...just one psychiatrist being able to keep you under the MHA, why is it just one person, one psychiatrist that can keep rolling it over and keep applying to the court. Unless you realise that you can ask for another psychiatrist to actually review it the same psychiatrist will keep reviewing it and if you don't get along with that psychiatrist that's just tough biscuits. It almost like, again, that power indifference, they have all the power." (Participant at tāngata whai ora hui)

"It shouldn't be possible for a family member to put you in hospital so easily because I think it is used by family members like, oh, you...don't behave the way I want you to behave therefore I'll send you back to hospital or I'll go and talk to your doctor, and they'll put you back in hospital under the Act. Or if you're put under it, it shouldn't just automatically roll over without actually scrutinizing why you're under it in the first place." (Participant at tāngata whai ora hui)

Tāngata whai ora spoke of the use of **coercion**, such as threats or perceived duplicity:

"I was sick of the coercion. You know if you don't turn up for your injection, we're gonna call the police. That's what they use every time to get you to come back for an injection. And I called them out on it and said alright then call the police, see what happens. And nothing happened. So, you know they had no leg to stand on... that way of communicating with people is not helpful and is not conducive to recovery or building trustworthy relationships...I don't think they should be saying anything like that." (Participant at tāngata whai ora hui)

"...the day before I went to the judge the doctors prescribed me, yeah I was quite coherent, aware of what was going on, prescribed me some medication at night... [I] took that... the next day I went in front of the judge to state my case to why I believe I should not be put under compulsory treatment and I woke up in the morning and I was a cabbage dribbling from the mouth...they basically just rail-roaded me into the compulsory treatment. It wasn't nice." (Participant in tāngata whai ora hui)

Tāngata whai ora felt services place **too much emphasis on medication**. They felt the default option was heavy medicalisation unless whai ora 'speak up' and advocate for themselves and with little review or scrutiny. Tāngata whai ora have talked about their fear of the long-term risks of taking medication as a cycle whereby more medication is needed to counter side-effects and they feel "brainwashed into taking medication forever."

"...People will be kept on medication ... putting people on medication and never reviewing it, just keeping people on the same level of medication and unless you have a little bit of knowledge or understanding, or you dare to speak up and go no, actually do I need to take this much medication? And you actually dare to question it or change it or actually start like to titrate yourself... you just become a good little pill swallower.... Or... you become really good at just going to get an injection and being injected time after time... and being pumped full of medication... and nobody ever asking if you actually need that amount of medication." (Participant at tāngata whai ora hui)

"...the medication absolutely annihilated me. It just blew me off my tree. I was off the planet. It did something to me that changed my life... they call it a chemical lobotomy. It is one of the scariest things that could ever happen to you a chemical lobotomy, and I wouldn't wish it on my worst enemy because

it is life changing. My energy levels were at 78 percent before the lobotomy, after the lobotomy, when they put me on the injection, my energy levels dropped to 10 percent." (Participant at tāngata whai ora hui)

"It's horrible. You're on so much medication and you wake up and your pillow is completely soaked because of, you know, the clozapine... or whatever you're on, for me it was clozapine... you just wake up and your night dress is all wet on the shoulders because of the saliva..." (Participant at tāngata whai ora hui)

Tāngata whai ora spoke strongly to **the lack of culturally appropriate services** and approaches and a system that reflects a dominant European worldview. The current MHA is silent on Te Tiriti o Waitangi.

"We are still, as Māori, not made to feel like it is okay to be Māori. In the [clinical] practices, you know, when we ask things, when we talk about our Māori-ness, it's like we haven't spoken at all. They don't take any of that into account." (Participant at tāngata whai ora hui)

Perverse incentives exist and **reinforce a system of compulsory treatment**. These include better access to medical care, free medication³ and even the structure and social interaction that community treatment orders provide for tāngata whai ora with chronic mental illness who may be lonely and on the margins of society.⁴ Tāngata whai ora also spoke 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 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 whai ora hui)

Compulsory treatment orders do not guarantee someone will be safe from harm. We are aware of cases where the issuing of a compulsory treatment order is likely to have contributed to suicide rather than prevented it.

Whānau involvement throughout the MHA, and access to support to understand and navigate the MHA, is poor and inconsistent across regions and the current obligations under the Act to consult and engage whānau are passive.

³ Baker. (2015). He kai I nga Rangatira: He korero o nga whānau whaiora. Wellington: Te Rau Matatini Limited.

⁴ Newton-Howes G & Ryan CJ. (2017). The use of community treatment orders in competent patients is not justified. Br J Psychiatry;210(5):311-312.

The lack of services to manage and care for people experiencing alcohol and substance use and harm, including toxic delirium and drug-induced psychosis, is adding significant pressure on mental health in-patient units and staff.

Part 2: Recommendations for new legislation

Section A: The MHF supports legislation to absolutely minimise compulsory treatment and restraint no later than 10 years from the new legislation coming into effect

"[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 whai ora hui)

The MHF recommends the new mental health law all but end compulsory treatment and restraint, reducing these practices to the barest of minimums by a date no later than 10 years from the new legislation passing into law. We believe a firm legal commitment to the absolute minimisation of compulsory assessment and treatment and restraint practices is necessary to provide the impetus needed to make substantive gains, in a timely manner, to the way people are supported when they are severely mentally unwell. Without a clear legal commitment, the inertia of the system and vested interest in the status quo will subvert any intent to change practices and the existing high rates and inequitable application of compulsory treatment orders.

Our recommendation accepts there may be an exceptionally small number of cases where the use of compulsory treatment and/or limited restraint practice might be necessary for a short period of time, for example for a person's safety or where a person experiences impairment of decision-making skills and, after exploring all options, it is not possible to establish their will and preferences. However, this should only occur within a legal 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.

Importantly, the absolute minimisation of compulsory treatment does not equate to the abandonment of support and care. The [World Health Organization](#) (WHO) is clear there are ample examples of crisis services that provide effective care and support as alternatives to the use of coercion. Supporting these types of alternative models will mean heavy investment to 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 identity, and approaches based on holistic models of care. 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.⁵

Just as work to achieve zero seclusion has required a decade's deliberate work to change practices, a similar programme of work is required to enable the absolute minimisation of compulsory treatment and restraint, and a legal mandate to develop and enact a plan to implement key service development and practice changes will be critical – see Part 3 for the service and system changes required and in particular recommendation 9.

This goal of absolute minimisation of compulsory treatment and restraint within 10 years after enactment of the new law can be achieved through a two-stage process that progressively tightens the use of compulsion and increases scrutiny, while providing a decade for service development and change of practice. Stage one would significantly reduce the use of compulsion and stage two would build on the regulation and practice changes in the first stage and will require a further tightening of legal restrictions and scrutiny, perhaps eight years after the law is enacted, to provide the system time to adjust.

Recommendation 1: Design legislation to absolutely minimise compulsory assessment and treatment and restraint no later than 10 years after the new legislation comes into effect, through a two-stage process. Stage one being interim steps to immediately significantly reduce compulsory treatment and restraint (recommendations 3a-3q), and stage two being the introduction of an additional layer of legal restrictions and scrutiny that come into force at the 10-year mark.

Section B. Prohibit seclusion practices in law

"I'd like to see things like seclusion in particular removed. I don't think there's any therapeutic value in it whatsoever and that's evidence-based as well...I...feel really strongly that as long as it's an option it's always going to be an option for staff to use...I'm aware some spaces of seclusion are called things like the retreat, if you compare the word retreat with what other people outside the system refer to as a retreat it would not be that, in fact they would be mortified and think what the heck... it upsets me that things like that are happening and I don't think that should be acceptable to be honest." (Participant at tāngata whai ora hui)

Seclusion is completely inappropriate and should be a thing of the past. It causes distress to both patients and staff, and poses significant risks to tāngata whai ora, including death, re-traumatisation, loss of dignity and other psychological harm. We must not continue to accept that seclusion is necessary. We know the elimination of seclusion is possible and sustainable even in urban centres with diverse

⁵ Douglass, Young & McMillan (2020). Assessment of Mental Capacity: A New Zealand guide for doctors and lawyers. Te Herenga Waka University Press: Wellington.

populations.⁶ This is supported by New Zealand-based evidence suggesting environmental factors such as service delivery models and practice approaches are key factors in supporting reductions in restrictive practices rather than sociodemographic and clinical factors.⁷

"Aspirations for zero seclusion need...to have real weight behind them to drive change"⁸ and this process to repeal and replace the MHA is the best way to ensure there is no space for legally sanctioned seclusion practices to continue. The MHF have previously supported a national multidisciplinary oversight mechanism to support and monitor the on-going commitment needed in our services and workforce to achieve zero seclusion.⁹

Recommendation 2: Prohibit the use of seclusion practices in mental health units when the new law comes into force, sending a clear signal in advance of the legal change, and supported by resourcing and independent oversight.

Section C: Design new mental health legislation to reduce inequities and significantly reduce compulsory treatment and restraint as an interim step towards the absolute minimisation of these practices.

"I feel that, yes, it should still be there because it's got a time and a place but the way people are put under it, it should be far more scrutinised and not as easy to put people under it and not as easy to keep renewing it." (Participant at tāngata whai ora hui)

As an interim step, and supported by *He Ara Oranga* and *Kia Manawanui Aotearoa*, the MHF supports compulsory treatment and restraint being significantly reduced and to stop the inequitable use of these practices against populations groups, especially Māori. We believe this can be achieved through the following:

- frame restraint practices as a service failure with additional scrutiny and debrief
- design legislation based on an indigenous model with Te Tiriti o Waitangi as the foundation
- embed a strong supported decision-making framework into law and practice immediately and ensuring it is available to all tāngata whai ora, at any time of the day and week

⁶ <https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/news-and-events/news/4395/>

⁷ Lai, Jury & Long et al. (2018). Variation in seclusion rates across New Zealand's specialist mental health services: Are sociodemographic and clinical factors influencing this? *International Journal of Mental Health Nursing*. doi: 10.1111/inm.12532

⁸ Dr Sharon Shalev and New Zealand Human Rights Commission, 2020. *Seclusion and Restraint: Time for a Paradigm shift. A follow up review of seclusion and restraint practices in New Zealand.*

⁹ MHF [submission](#) (2020) to Dr Sharon Shalev follow up report to 'Thinking outside the box'.

- legislate for a higher threshold of entry to compulsory treatment, and
- enhance scrutiny and protections for compulsory treatment.

Recommendation 3: Design new mental health legislation to significantly reduce compulsion and restraint as an interim step towards the absolute minimisation of compulsory treatment and restraint.

Frame restraint as a service failure

"...they just chemically restrain people you know if you don't behave...the way they want you to behave. They just pump you full of medication and then you definitely don't say anything or do anything, you just sit in the corner dribbling, literally dribbling." (Participant at tāngata whai ora hui)

"if they...do do restrictive practice or they put you in seclusion there's no accountability there. They're not accountable to anyone but themselves...there needs to be an external party involved that overseas the accountability because at the moment they're using restrictive practice... for me they used it to control my behavior when it didn't suit their needs... it wasn't around risk it was around controlling behaviour." (Participant at tāngata whai ora hui)

"...I get it if someone's extreme danger to self or others there needs to be some kind of restriction...if there has been a restriction they need to be able to prove that in court of law that yes that person was an absolute danger to self or others" (Participant at tāngata whai ora hui)

Chemical, environmental and physical restraint has no therapeutic value and causes trauma and distress. There is evidence that in Aotearoa it is not used during emergencies or as a last resort and for the shortest time possible,¹⁰ and that inconsistent use of terminology and definitions across DHBs justify variations in practice. Tāngata whai ora felt it was used by clinicians to control their behaviour rather than to manage safety.

Recommendation 3a: Legislation should frame the use of restraint practices within in-patient units as a service failure, with each incident triggering an external review and de-brief with the person, whānau, peers and clinicians. The review should explicitly examine racial and gender bias and seek to determine what service and practice improvements and resource are needed to provide safe and effective alternatives.

Recommendation 3b: Introduce national guidelines for the consistent collecting and reporting of restraint use across DHBs and by service user demographics and make this information publicly available. Data should be collected on types of restraints, the absolute numbers of restrained people, how many times they were

¹⁰ Dr Sharon Shalev and New Zealand Human Rights Commission, 2020.

restrained and for how long, counts of restraint incidents and people restrained per day per 1 million population, and statistics on duration for each type of restraint.¹¹

Recommendation 3c: Annual review and publication of the effectiveness of implementing strategies (e.g., Six Core Strategies) on reducing restraint practices and its impact on injury and assault rates.

Te Tiriti o Waitangi as the foundation

We support developing legislation that directly references Te Tiriti o Waitangi articles and outlinings how the Act will give effect to Te Tiriti o Waitangi. The new law should make explicit reference to the following:

- Te Tiriti o Waitangi preamble – Māori should be equal or lead parties in compulsory treatment and assessment processes and decisions.
- Kāwanatanga – the law should enable openness, sharing of power and equitable Māori participation. In particular, the law should reserve the right for Māori to review and override decisions about applications for compulsory treatment for tāngata whai ora Māori. This could include a regional Māori review tribunal made up of whai ora Māori, iwi and hapū representatives, and Māori mental health professionals. This scrutiny should happen as soon as possible after a person is assessed as requiring compulsory treatment.
- Rangatiratanga – using Māori values to influence and hold authority in supported-decision-making processes, and care and treatment and compulsory treatment decisions, including acknowledge collective decision-making and collective sense of self and seeking ways to care for a person through tikanga Māori as the first step.
- Ōritetanga – encouraging Māori to exercise their citizenship as Māori through mandating the routine use of cultural assessment for all tāngata whai ora, improve access to culturally appropriate advocacy services after hours, and require all tāngata whai ora Māori who come into contact with specialist mental health and addictions services to be offered access to support by Māori and ways to connect to Māori culture (e.g., te reo Māori, whakapapa, access to whenua, marae, and mātauranga Māori).¹²
- Wairuatanga – the law should acknowledge the importance of wairua, rongoa and hauora throughout a person’s recovery and in the delivery of mental health services and care.

11 Newton-Howes, G., Savage, M., Arnold, R., Hasegawa, T., Staggs, V., & Kisely, S. (2020). The use of mechanical restraint in Pacific Rim countries: An international epidemiological study. *Epidemiology and Psychiatric Sciences*, 29, E190. doi:10.1017/S2045796020001031

¹² Baker.2015. He kai I nga Rangatira: He korero o nga whānau whaiora. Wellington: Te Rau Matatini Limited.

Recommendation 3d: Design legislation based on an indigenous model with Te Tiriti o Waitangi as the foundation, directly reference Te Tiriti o Waitangi articles and outline how the law will give effect to Te Tiriti o Waitangi, such as routine cultural assessments, protected access to support by Māori and ways to connect to Māori culture, and reserve the right for Māori to review and make the final decision about applications for compulsory treatment for tāngata whai ora Māori.

Recommendation 3e: Authorise a Māori rōpū comprising at the very least lived experience, whānau and mental health specialists to develop the policy recommendations and write the drafting instructions for the new law alongside the Ministry of Health.

A strong supported decision-making framework in mental health law

Tāngata whai ora we spoke to supported services and clinical practice being oriented towards supported decision-making and self-determination of goals.

"I see our Māori people and they are just giving them medication so I would talk to the clinical services about helping them become self-determining, helping them to find out what's going on with them. I really wanted [them] to make these decisions for themselves." (Participant at tāngata whai ora hui)

"The whole thing about clinical services [is it] should be about helping people advocate for their own destiny, for their future, and start working towards that..." (Participant at tāngata whai ora hui)

"Clients should be in charge of their own healing...working in conjunction with mental health professionals" (Participant at tāngata whai ora hui)

At its most basic supported decision-making can be defined as requiring all forms of support, including the most intensive, being based on the will and preferences of the person concerned. Supported decision-making aligns well with whanaungatanga and recognises the supportive role of the extended family and relating well to others.¹³ There is reasonable evidence that, when done well, supported decision-making, and especially advance directives, are effective means to reduce the use of compulsory treatment and relay a very real fear and anxiety associated with certain medication and treatments.¹

"...my greatest fear is when I'm put under Mental Health Act – like what happened about six month ago – is the knowledge that some Dr can go 'hey we're now going to do...ECT'...because they are still allowed to do that..." (Participant at tāngata whai ora hui)

The law should enshrine the core principles of supported decision-making to support best practice for those who are experiencing severe mental distress, including the following:

¹³ Douglass, Young & McMillan (2020). Assessment of Mental Capacity: A New Zealand guide for doctors and lawyers. Te Herenga Waka University Press: Wellington.

- The presumption that tāngata whai ora can make decisions without support and should have the opportunity to do so before support is provided, and at every stage in the support process, to maximise autonomy. Some tāngata whai ora may need support to make their own decisions, just as everyone does from time to time.
- Supported decision-making needs to be accessible at all times, including after hours.
- Check and balances to ensure supported decision-making is done routinely and regularly.
- Timing is important. If someone is unwilling or unable to engage in the process, supported decision-making should be revisited. When a decision is not urgent it is important to take time and not pressure a decision. People may need time to consider and research options and to consider and confer with others they trust.
- Decisions should aim to achieve recovery and regain mental health, not risk avoidance.¹⁴ A person has the right to make the decision, even if their support person or a professional disagrees with this decision.

"Taking risks is part of life so for clinicians to work from a risk-averse way is not helping the individuals to regain control over their lives and build confidence and work towards recovery. Learning from mistakes is another important part of life so individuals need to be allowed to experience this otherwise how will they ever learn to thrive in their communities." (Lived experience correspondence)

- Tāngata whai ora should be included in discussions about them and at all decision-making stages.

"I have also been left out of multi-disciplinary meetings...In the last MDT I had to ask three people what happened to get a clear picture of what decisions were made about me. One nurse relayed me incorrect information which triggered me and sent me into a spiral. This could have all been avoided if they just let me sit in on the meeting. I spoke with two nurses and finally the psychiatrist to get the full picture. We could have avoided the stress." (Lived experience correspondence)

- Tāngata whai ora need access to information from a range of sources, including the ability to do their own research and speak to experts and peers. Information may need to be repeated at different times.

"In terms of medication, this involves giving individuals good options for medication, having the pharmacist talk through the options with them and providing a range of information about different medication options. It is also about giving the individual the right to do their own research. There should be opportunities in in-patient units for individuals to access computers to attain

¹⁴ Mellso, G., Ellis, P. M., Glue, P., Gale, C., Mulder, R., & Menkes, D. B. (2015). Risk management and clinical practice. *New Zealand Medical Journal*, 128(1424), 42-44.

research about medication options. This is also another important situation to involve whānau in, decisions about medication. Both the individual and whānau should be supplied with best possible and current research into medication options. Questions around medication options should be encouraged by all clinicians. There is also room for lived experience input, with a LE individual having conversations with an individual about their experience with different treatment options." (Lived experience correspondence)

"Where are the credible educational resources for the consumers? In-depth resources. Not a one-pager. I feel like a pamphlet in itself makes an assumption that only those who have low intelligence would get a mental illness diagnosis and therefore only require a little educational input. How can I make any informed decisions if I don't know? Even on the ward, I hear the nurses asking me "what do you want?" "What works for you?" and I am thinking to myself "well, clearly I haven't worked out a strategy for what does work for me that is why I am here. Please help me and tell me what my options are." The same with the psychiatrist. Who is very good by the way. But how would I know what medications are available to me? I need her suggestions and then I can make a decision. It is very frustrating..." (Lived experience correspondence)

- Opportunities for collaborative note taking and dialogue, and access to clinical notes at a time of their choosing can help to increase understanding and a feeling of empowerment. This is rarely done at present.

"I think at some stage a person should be able to contribute to their notes of their own accord whatever that looks like in their own words when they're ready and when they want to. It should be an option. And I don't think clinical notes alone should be OK and I think it leaves a lot of room for abuse to happen as well." (Participant at tāngata whai ora hui)

Whānau involvement

Overall, most tāngata whai ora we spoke to wanted whānau to be involved in their care, in supported decision-making about treatment and medication as well as capacity assessments. They recognised the valuable role whānau play to support a loved one subjected to the MHA.

One participant noted the 'open dialogue approach' in Finland, where whānau and providers work together with the person in a crisis to improve social relationships and outcomes, was a way of supporting someone with 'everyone in their life'.

Whānau also want to be involved in decisions and care and to be shared information to help them care for a loved one.

"There need to be whānau involvement right from the beginning of an individual's care. Often whānau are left out and their opinions and thoughts are not acknowledged [until] further down the treatment process. In the beginning is often when the individual is most distressed and having that whānau involvement is critical in supporting that person. There needs to be more whānau involvement

in the MHA process including input into the court hearings and decisions clinicians make. When a clinician is assessing the MHA this should include whānau input and opinions.... whānau, friends, work colleagues can be the people that know the individual the best so the best decisions about that individual's treatment should involve them..." (Lived experience correspondence)

Tāngata whai ora should choose who may support them to make decisions (e.g., whānau members, partners, friends, and peer advocates etc) and advance directives, wellness and recovery plans, [health passports](#), and communication support plans can help, especially during crises. It was noted the 'nominated individual' approach (in Victoria, Queensland and United Kingdom) could be useful and that health professionals should frequently revisit with the person who needs to be involved in supported decision-making because family relationships can change over the course of illness and recovery.

We recognise there may be conflict or disagreement between tāngata whai ora and that whānau can be a source of discrimination.¹⁵ Where conflict arises, tāngata whai ora must have the right to decide or decline the involvement of whānau or particular individuals, with the full knowledge this may impact on their care or ability to transition back to the community or home, and be able to change this decision at any time.

Advance directives

Tāngata whai ora must be empowered to create advance directives and wellness and recovery plans, with their whānau and clinical team, and clinicians must respect these future legal directives. Advance directives, if consulted and implemented, give tāngata whai ora a voice and draw on their experience-based expertise as to what helps them during mental distress.¹⁶ Advance directives should be part of the routine admission process to secondary services and part of primary mental health care. Peer workers, who understand what issues and decisions need to be considered in an advance directive and can give advice about the implication of medications and of the MHA, should have a role in developing them alongside tāngata whai ora.

The new law should clarify that a valid advance directive will be legally binding in community and in-patient settings, and ideally it would provide a framework for creating valid advance directives for mental health care. Some tāngata whai ora were sceptical that even if they made an advance directive it would not be known about or used by clinicians so processes need to be in place to identify an existing advance directive.

¹⁵ Flett, J. A. M., Lucas, N., Kingstone, S., & Stevenson, B. (2020). Mental distress and discrimination in Aotearoa New Zealand: Results from 2015-2018 Mental Health Monitor and 2018 Health and Lifestyles Survey. Wellington: Te Hiringa Hauora/Health Promotion Agency.

¹⁶ Thom, K., Lenagh-Glue, J., O'Brien, A. J., Potiki, J., Casey, H., Dawson, J., & Glue, P. (2019). Service user, whānau and peer support workers' perceptions of advance directives for mental health. *International Journal of Mental Health Nursing*, 28(6), 1296-1305.

"...Down here they have a thing called a WRAP plan or a wellness recovery action plan...you fill it all out with all the great intentions and oh this is going to be wonderful, this is going to be awesome, and then they put it in the file and forget about it and then they continue to ask questions...and I say oh I put it in my WRAP plan and [they say] oh we didn't want to look it up."
(Participant at tāngata whai ora hui)

"I love WRAP plans, I love all that collaborative stuff, but at the end of the day when it comes the crunch it's not really taken into account or it holds no legal standing in any way possible so it's no match compared to a clinician's recommendation..." (Participant at tāngata whai ora hui)

Whānau also need access to information and advice, such as how to support a person when entering crisis, and wellness and recovery plans shared with whānau members would be useful here.

Recommendation 3f: Enshrine in law a supported decision-making framework in line with the Code of Health and Disability Services Consumers' Rights, emphasising the presumption that all tāngata whai ora can make their own decisions and have the right to access supported decision-making at all times, including after hours.

Recommendation 3g: Include a more active legal obligation for the engagement of whānau in all aspects of a person's involvement in the Act within the context of a supported decision-making framework, and provide dedicated support and tools for whānau to understand and engage with the Act and the mental health care and wellbeing of their loved one.

Recommendation 3h: Advance directives should be given a legal mandate in primary legislation to clarify their legal status and the new law should set out a framework for creating valid advance directives for mental health care.

Recommendation 3i: Secondary mental health services must have robust processes in place as part of admission to easily identify an existing advance directive.

Set a high threshold for entry for compulsory treatment

At a minimum, legislation should restrict compulsory treatment on the basis that it is the last resort, that treatment is the least restrictive option and will be effective in their recovery, as is the case in other jurisdictions such as the United Kingdom and NSW and Victoria.

The difficulty with predicting future risk is well documented. We suggest that, if risk is considered part of the criteria for entry, that consideration be given to a shift away from predictive risk to evidence of actual harm. Furthermore, risk criterion could be narrower than the current MHA, which allows compulsory treatment if it is judged there is a risk to others. This is out of step with evidence that people diagnosed with mental illness are a low-risk group for committing acts of violence and are in fact more likely to be the victim of violence than the general public.ⁱⁱ Doing so would also

be in line with the Substance and Addiction (Compulsory Assessment and Treatment) Act.

We note capacity-based legislation is not in line with the CRPD (which prohibits any form of substituted decision-making) and there is some evidence, for example in Norway,¹⁷ where they found no decrease in use or duration of compulsory treatment orders after the introduction of capacity-based mental health legislation. If a capacity-based test is the preferred approach for Aotearoa, we recommend a person's will and preferences remain central to the decision-making process, regardless of whether they experience impairment of decision-making skills. This would include the views of the person expressed directly, or in care or relapse prevention plans, through their whānau and in an advance directive. In practice this would mean any impairment of decision-making skills would trigger an exploration of the nature of support required to enable individuals to make decisions rather than resulting in a person being denied the ability to make a decision altogether. Consideration should also be given to an interpretation of capacity that supports a te ao Māori perspective, such as the kupu 'āheitanga' that incorporates what you can accomplish and absorb and what you hold within yourself.

"Capacity I think is very white, I can't think of another word to describe it, and we have plenty of white words and I think if we're going to come up with a definition it needs to be a Māori definition and it won't be the word capacity." (Participant at tāngata whai ora hui)

Under capacity-based legislation, a higher threshold of entry to compulsory treatment will likely mean there will be a small number of competent people who will refuse mental health treatment and who may also experience suicidal distress, and who no longer meet the criteria for compulsory treatment. We stress that a higher threshold of entry to compulsory treatment does not also equate to the abandonment of support and nor is compulsion a guarantee to the safety of those experiencing suicidal distress. There is no doubt the creation of a mentally healthy society in which people do not want to attempt suicide in the first place is the best way forward¹⁸, as is a whole-systems response to ensure people can be safely accommodated and offered appropriate support and services.¹⁹ Other possible consequence of restricting compulsory treatment include deterioration of health that may become life threatening and a risk people will languish in the community once they regain capacity and will only re-engage with mental health services when they become extremely unwell and lose capacity.²⁰ It will be important there are sufficient resources available to ensure the smooth transition of people from

¹⁷ Høyer, G., Nytingnes, O., Rugkåsa, J., Sharashova, E., Simonsen, T., Høyer, A., & Riley, H. (2022). Impact of introducing capacity-based mental health legislation on the use of community treatment orders in Norway: a case registry study. *BJPsych Open*. 8 (1).

¹⁸ Wilson, 2018. The Call for the Abolition of Mental Health Law: The Challenges of Suicide, Accidental Death and the Equal Enjoyment of the Right to Life. *Human Rights Law Review*, 18, 651–688.

¹⁹ Gordon and O'Brien 2014. New Zealand's mental health legislation needs reform to avoid discrimination. *NZMJ*, Vol 127 No 1403

²⁰ Recordon, 2020. *A Little Less Discrimination, a Little More International Legal Compliance: A Capacity-based Approach to Substitute Decision-Making for People with Mental Illness*

involuntary to voluntary status once decision-making skills are restored – see Part 3 of our submission.

Recommendation 3j: Set a high threshold for entry into compulsory treatment in legislation, including that it is the last resort, that treatment is the least restrictive option and will be effective in their recovery; and exclude 'risk to others' in the criteria.

Recommendation 3k: Any capacity-based approach should ensure a person's will and preferences, expressed either directly or previously, remain central to the decision-making process even if they experience impairment of decision-making skills.

Enhance scrutiny and protections for compulsory treatment

Tāngata whai ora want more oversight and scrutiny of compulsory treatment applications and decisions, including decisions being made in collaboration with tāngata whai ora, clinicians and whānau.

"If someone is in hospital and they're obviously needing to be supported in a safe place then ...that could be put in place with a family meeting where everyone in the family, the friends, and everyone decides that the person does definitely need that level of support for that amount of time. And then after a time, maybe two weeks or one week it's reviewed and the person isn't automatically kept under the Act but it's completely review by everyone again to see whether it's absolutely necessary or the person can make their decisions for themselves at that time. So, at every time there is a review everyone involved in the kōrero so it's not just the medical model that's getting a say." (Participant at tāngata whai ora hui)

"...there needs to be peer and clinical and cultural partnership around overseeing a compulsory treatment order not just [psychiatry] overseeing that because they are killing us, they're killing our people." (Participant at tāngata whai ora hui)

"So for compulsory treatment, no it needs to be a partnership between not only the client and the clinician but the entire whānau or if it's not whānau the key...relationships in a person's life to work through together." (Participant at tāngata whai ora hui)

Some tāngata whai ora spoke about a court system being bewildering, isolating and not conducive to recovery. Whānau said they want to be engaged and participate in the court process.

"I had a Mental Health Act hearing, I saw a lawyer for maybe 5 mins before my hearing...so how they could possibly understand who I was, what I wanted, and how I wanted to proceed, they just couldn't have...they didn't have enough information to be able to represent me. I felt disempowered in that process...and the lawyer just said things like "why not follow what the doctor plans for you?" It was terrible. If you're going to establish a therapeutic relationship where people are feeling valued, supported and

respected then you don't treat them like that. I've sat there waited for my hearing and I've seen other people walk in the door and as they didn't know it was their hearing that day, a taxi has scoped them up, brought them to the unit and as they are walking through the door they are saying this is your lawyer and then they are in the hearing. That's no way to treat people. There's no preparation there, no support, no awahi. Nothing." (Participant and tāngata whai ora hui)

Recommendation 3i: Assessments for compulsory treatment should be made by multi-disciplinary teams, not single clinicians, and in collaboration with the person, a peer support worker, cultural advisors and whānau.

Recommendation 3m: Establish shorter assessment periods and a shorter compulsory treatment order period, compared to the current system, with regular periods of review.

Recommendation 3n: Establish a specialist mental health court or tribunal (rather than the Family Court) with processes designed with tāngata whai ora at the centre, and ensure all employees of courts and/or tribunals, including lawyers and judges, receive training in mental illness/distress, including communication skills, and stigma and discrimination awareness.

Recommendation 3o: Consider specific legal protections to restrict the use of procedures such as ECT and medications with significant side-effects and long-term impacts.

Recommendation 3p: Establish a comprehensive advocacy framework in the law to strengthen access to independent legal and peer advocates for redress and support.

Recommendation 3q: The law should establish independent oversight mechanisms regarding its application, including annual reporting and with monitoring and advocacy powers to recommend system changes.

Section D: Role of police

"...For me I have experience where I had a terrible manic episode and the police found me and took me to [the ward]. Now, I'm not kidding you, the way that they treated me...I had on handcuffs, I was taken through the back past all the washing and rubbish, you know, before I actually got up to the ward. To be honest I didn't feel like a sick person. That made me feel like an animal and a criminal as a punishment for getting sick, you know? That was really, really hard. They put handcuffs on so tight that it really hurt my wrists. I felt like a criminal...not like a person..." (Participant at tāngata whai ora hui)

"I was taken to hospital by the police and they handcuffed me and I was unwell and I was sitting in the back of a police car handcuffed and I just cried... I am really unwell and I am handcuffed like a criminal but I'm unwell. It's not like I was angry or I was aggressive, nothing like that," (Participant at tāngata whai ora hui)

"It's like you're a criminal....I think...that fact of being uncuffed in the back of a police car that to me that was 11 years ago but it was so traumatic – that was way more traumatic than the trauma that was going on in my life at the time and the trauma that had previously happened...that was a really really traumatic experience and took me quite a few years to actually trust police again." (Participant at tāngata whai ora hui)

"What is sad...when you're sick you get taken in an ambulance and the ambulance people look after you...they are the most loving people. You don't get handcuffed in an ambulance when you're unwell." (Participant at tāngata whai ora hui)

Tāngata whai ora told us that police responses can be very traumatic when being transported by police in handcuffs to in-patient units or emergency departments. The MHF and the police²¹ agree police should not be routinely responding to people experiencing severe mental distress and that an alternative health-based response is preferable. We accept police do have a role in community settings where there is a risk of harm, but they must be supported with a health and peer-led response, as well as mental health, including anti-discrimination and prejudice, training. We have heard anecdotal evidence the co-response team pilot in Wellington is proving successful.

Recommendation 4: Increase capacity for a health-based crisis response and rapidly scale up successful local pilots of co-response arrangements where police are supported by peer and health responses.

Section E: Forensic mental health

The MHF have previously supported a whole-of-systems approach to the insanity defence process and how robust improvements could be made to effect fair outcomes for all parties, including for victims. We suggested the recommendations from the 2010 Law Commission's report *Mental impairment decision-making and the insanity defence* provide a useful blueprint for reform.²² In particular we urged the government to support the recommendation made by the Law Commission for a move away from Ministerial decision-making about the reclassification or discharge of a special patient or special care recipient to a model where these decisions continue to be clinically initiated but are based on broader public interests, taken into account by a specialist independent tribunal.

Recommendation 5: Revisit recommendations from the 2010 Law Commission's report *Mental impairment decision-making and the insanity defence*, specifically move away from Ministerial decision-making about the reclassification or discharge of a special patient or special care recipient.

²¹RNZ, 19 November 2021. As police call-outs for mental health issues rise, the commissioner wants a new approach. <https://www.rnz.co.nz/news/national/456062/as-police-call-outs-for-mental-health-issues-rise-the-commissioner-wants-a-new-approach>

²² MHF submission to Justice Committee. 2020. Rights of Victims of Insane Offenders Bill

Section F: Physical health equity

"Young friend of mine, he's 27, he's been on clozapine since he was 15, he was told last week he's now got cancer throughout his...both his hips, through his stomach, and in his lymph system and...he's basically got months to live now. I've heard those stories time and time again. I've lost three of my friends so far because of clozapine. That drug is killing our people and it needs to stop." (Participant at tāngata whai ora hui)

The MHF supports the inclusion of 'parity of esteem' principles in the legislation to provide a legal mandate to address the significant physical health inequities that exist in Aotearoa between people who experience mental health and addictions challenges compared to the general population. We note there are several international examples of legislation that cover physical health equity in the context of mental health/illness, such as the US 2008 Mental Health Parity and Addiction Equity Act and UK Health and Social Care Act (incorporating Parity of Esteem).

Recommendation 6: Support parity of esteem principles in the new law to address physical health inequities experienced by tāngata whai ora.

Section G: Intersectionality and population groups

Many of the points and recommendations in our submission apply to specific population groups, including the elimination of seclusion practices, more trauma-informed, culturally responsive, identity affirming and whānau inclusive approaches, and strong monitoring and oversight of the mental health services and the application of the law. We recommend the Ministry of Health work alongside specific population groups and their representative bodies to ensure the legislation recognises and responds to the unique needs of these groups, as well as their experience of overlapping and interdependent systems of discrimination or disadvantage (intersectionality). Some specific points we support include:

Tamariki and rangatahi: inpatient settings should be the last resort and must provide therapeutic and child-friendly environments; separate facilities for tamariki and rangatahi or where they must be combined with adult services a separation of adults and rangatahi, supporting tamariki and rangatahi to work in partnership with whānau and clinicians about their treatment and to have a voice, and independent monitoring of functions to monitor and report on the application of the law.

Intellectual disabilities: We are aware of a lack of services and workforce able to respond to people with intellectual disabilities who experience mental distress, barriers such as diagnostic overshadowing and concerns about the overuse of medication; supported decision-making is highly valued and there may be specific communication needs that need to be taken into account.

Refugee and migrant communities: Services must provide trauma-informed, holistic and culturally safe support and treatment, access to interpreters, and enhance the cultural capacity of the workforce including training, multi-ethnic teams and a multi-ethnic mental health support workforce.

Rainbow communities: legislation can support the provision of care that affirms and validates identity, gender and sexuality, for example, Victorian State mental health law includes a principle to 'recognise that individuals may have specific gender-related needs and experiences'. Outside of the legislation, services should ensure they hire rainbow and takatāpui individuals to be part of the mental health workforce at all levels, particularly psychiatric nurses and doctors. This will better ensure clinical staff have a real understanding of the experiences of rainbow and takatāpui tāngata whai ora.

Recommendation 7: In consultation with population groups and their representative bodies, include explicit principles and rights in the legislation to ensure they receive appropriate and compassionate care and support that responds to their background, identity, culture and circumstances.

Section H: Pandemic futureproofing

We note legislation will need to be future-proofed to deal with the on-going public health impacts of the COVID-19 pandemic. We suggest the Ministry of Health's guidance to practitioners on the use of audio-visual technology in mental health assessment and examinations be incorporated into the new legislation and monitoring and public reporting be legally required to ensure these practices are used appropriately.

Recommendation 8: The Ministry of Health's guidance to practitioners on the use of audio-visual technology in mental health assessment and examinations, and monitoring and public reporting requirements about its use, should be incorporated into the legislation.

Part 3: The absolute minimisation of compulsory treatment and restraint over 10 years in legislation must be supported by a major programme of changes to systems and practices

*"it's more of a systematic issue than just changing the mental health act"
(Participant at tāngata whai ora hui)*

"If we have a setting where the environment was absolutely beautiful, and you had the right people in there, and the places that we had available were somewhere people wanted to go, it would remove a lot of the reason for compulsory treatment orders." (Participant at tāngata whai ora hui)

Significantly reducing and then absolutely minimising compulsory treatment and restraint in legislation must be supported by equal changes to systems and practices. It is these systems and practice changes that will better prevent mental distress and provide new and scaled up models of care and support to replace the need for compulsory treatment processes and restraint practices.

Our moemoeā (pages 10-12) sets out a high-level outline of what supports, care and services, rights and cultures are needed for tāngata whai ora to enjoy their rights on an equal basis with others. It builds on what tāngata whai ora have told us, well-established models such as the [Wellbeing Manifesto](#) and insights from the Mental Health and Wellbeing Commission. It spans the full spectrum of fundamental rights, prevention, promotion, primary care, crisis response, community mental health, specialist services and criminal justice.

We highlight several aspects below in more detail, drawing on quotes from tāngata whai ora and whānau.

When we asked tāngata whai ora "how should the health system respond when we are experiencing mental distress?" answers focused on being protected, supported and cared for with manaaki, respect and compassion.

"Number one they should be there, you know, to care for us and to protect us. Because at the moment I feel we're ...just left out a bit...so there should be a bit more protection there and care. We're not just numbers we're people going through really difficult stuff at times... there should be more understanding, more compassion, more empathy... because...when I was sick I met a range of workers and some of them didn't have that." (Participant at tāngata whai ora hui)

"...all we are really doing is asking for help. We are in crisis and we don't know what's going on. Just help us..." (Participant at tāngata whai ora hui)

"When an individual is severely unwell both them and their whānau need to feel heard and validated...This time for whānau and their loved one is very stressful so knowing their loved one is being cared for in a respectful and

careful way is highly important. They need to know they will not be harmed in any way during their treatment and that their rights will be upheld and respected." (Lived experience correspondence)

Tāngata whai ora want to be seen and heard and connected to as people and whānau.

"...I was there sometimes acutely unwell with hallucinations, did I need to be locked up? No I just needed someone to talk to and some space to chill out." (Participant at tāngata whai ora hui)

"[what] was really helpful for me was genuine human connection with others..." (Participant at tāngata whai ora hui)

They wanted health care professionals to carry out a process of whakawhanaungatanga and build trusting relationships with them so they can get to know them and understand what is going on in their lives.

"I'm going to say it again because I think this is really important that services really need to get to know you. And know who you are, what you believe in. Because the more you feel understood the more you could trust. The more you trust the less need there is for coercion or mental health act or anything else. So it's so important that people feel heard and appreciated." (Participant at tāngata whai ora hui)

"...it wasn't until last week when my psychiatrist sat down with me for an hour and 20 mins and we talked about my belief system, we talked about my history, what happened, how it happened, who was involved, what about my family. And it wasn't until she...became aware of all the like trust issues and power and control issues that she understood that being under the mental health act wasn't actually going to be good for me because in my eyes it was perpetuating the power and trust issues I had... I think it's really important that if they are going to do something as serious as put a mental health act on you then they know and understand what your background is and coming from a trauma informed place." (Participant at tāngata whai ora hui)

"if they'd built up that relationship with me in the hospital and...perhaps had access to a psychologist or someone to help me to understand why they thought a needle was important for me... maybe they wouldn't of needed the compulsory treatment order as well...I just think that building relationships is so important and I think that's how nurses used to be" (Participant at tāngata whai ora hui)

"When I first became unwell.... I realized..that my file from the past they didn't have that so they only had this tiny snippet of what happened a few years ago.... I got treated as this unwell person...without any knowledge of what happened in the past. And that was such a very skewered snapshot. If I already had a relationship...with the person or if someone built a relationship with me or even talked to me on that day and asked what is going on...what is happening for you right now, what has brought you to this point. And me being allowed to actually tell my story of what was actually going on for me,

things would have been so so so different." (Participant at tāngata whai ora hui)

Whānau wanted access to basic knowledge about a diagnosis, and manaakitanga and whakawhanaungatanga especially at the first point of contact when a whānau member is unwell.

Systems-level response

"I would like us to see us do something before I get to crisis point so I don't have to go down that avenue – there's so much more that could happen before we get to that stage" (Participant at tāngata whai ora hui)

The MHF have consistently argued for the mental health system transformation process outlined in *He Ara Oranga*, and now in *Kia Manawanui Aotearoa*, to be implemented in full. We suggest the expert input and the many stories of personal journeys shared by individuals, whānau and communities about what needs to change remain a rich source of solutions and innovations.

Many of the fundamental drivers of mental distress and inequity remain wicked problems that still require cross-government and political commitment. In particular, we need:

- A strong focus on **improving the social, economic, commercial and cultural determinants of health** such as homelessness, poverty and social exclusion.²³
"Housing stress is a significant issue for me.... stressing about the basics of housing and food etc." (Participant at tāngata whai ora hui).
- System changes that address **racism (individual, systematic and institutional) and differential access to care that result in more severe illness for Māori** – "for whānau when we do reach out it's usually at the ambulance end of the scale." (Participant at whānau hui). This includes continuing to build the Māori health workforce that is geared towards early intervention to address inequities in delayed diagnosis, presentation at emergency departments and late intervention, and often no intervention at all.²⁴ Cost of GP consultations are a barrier to primary mental health services.²⁵
- **Addressing the lack of mental health services available, high thresholds and waiting periods for admittance to specialist mental health services, and poor interconnection with other services.**²⁶ Inequities still exist in the provision of mental health services and choice of options in rural communities. These affect all New Zealanders but the greater rates of mental distress experienced by Māori suggested Māori are disproportionately affected.

²³ Durie, 2011. Indigenizing mental health services: New Zealand experience. *Transcultural Psychiatry* 48(1–2) 24–36

²⁴ Oakley Browne, Wells, & Scott, 2006 in Durie 2011.

²⁵ Gassin. 2019. Māori mental health. A report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Inquiry.

²⁶ Gassin, 2019.

Whānau also noted services and supports are not available when you need them.

- **Culturally competent health professionals** with access to mandatory cultural competency and cultural awareness training. We need to **support the growth of the Māori and Pasifika health workforce**.

"if I can be really frank our pākeha whānau they put them in the too hard basket even in the peer circles...I try to hire Māori whānau and it wasn't about qualifications, it wasn't about how they document well, it was about their heart because we needed...I saw the gap...and we needed those people in there to be able to awahi our Māori whānau" (Participant in tāngata whai ora hui)

"...as a Māori I'm facing people from everyone...Sri Lankan, Chinese, American, South African...they have no clue of what goes on for us as Māori and being in a Māori space and I think they don't have an interest in it." (Participant in tāngata whai ora hui)

"We need more Māori workforce... we need people with that Māori-ness about them." (Participant at tāngata whai ora hui)

- To **address discrimination and prejudice** by some health professionals and crisis responses, police and the public.

"Mental illness is a funny thing because you can't see it. If you've had a broken arm everyone gives you sympathy. But if you've got paranoid schizophrenia you're referred to as the crazy person, you know because people don't get it, they don't understand. So maybe too a bit more knowledge in that area...people with mental illness will not hurt you..." (Participant at tāngata whai ora hui)

- **Develop and invest in the peer workforce** (consumer, peer support and lived experience workforce) and support clinicians with lived experience with pathways to train, support and retain them in clinical and leadership roles.

"We need more lived experience in those clinical services." (Participant at tāngata whai ora hui)

- **Sustained funding of suicide prevention and responses, including kaupapa Māori responses.** Access to timely, coordinated, high quality mental health care is a critical component of suicide prevention, particularly for people with serious mental illness and substance use disorders. Coordinated, assertive, aftercare plays an important role in preventing suicide following an attempt – in the community and within inpatient units. This means supporting and equipping whānau to walk alongside those experiencing suicidal distress and to recognise when further support may be needed; and removing barriers to accessing this further support. 'Circuit breakers' to interrupt suicidal distress experienced by people in the community can be promoted through respite, day respite, and short-term intensive support from crisis teams.

- We need **a separate system and parallel services to treat and manage alcohol and substance use**, including separate detox units to better support the needs of people experiencing substance use and addiction effects.

"I am in a ward that has mental health patients and patients with addiction together this is the norm. It is not conducive to recovery, and patients who need addiction support I believe should have their own facilities.... Speaking as a patient who is currently sitting on a mental health ward I feel very scared around those who are coming off drugs or alcohol. They are really volatile and their needs are much different from mine.... Another reason why addiction should be separated is their need for medical support from a medical doctor is really important. When they are coming off whatever drug they have been on they need to be supported by medical staff. Their bodies are going through hell." (Lived experience correspondence)

Whānau told us they need dedicated support with information and help navigating the system and "it needs to be delivered in a variety of ways including simple language, kanohi ki te kanohi and be culturally sensitive."

"Having a service that focuses on helping whānau make sense of mental health – don't think there is enough. I had to advocate for my whānau to get that support as it was expected for me to explain...and share back to my whānau. I live with 10-12 people so that expectation was intense." (Participant at whānau hui).

"...There is still so much misunderstanding out there...there needs to be so much more education around the mental health act...more accessible as well not just at hospital, in different places...unless you know what you're looking for you can't find it..." (Participant at tāngata whai ora hui)

Our ability to **divert people experiencing mental distress from the justice system and prison** remains a significant challenge. It requires early support in our communities, including responding to the intergenerational trauma of state care, particularly for Māori; better mental health training and awareness for police, lawyers, judges, and corrections staff to reduce discrimination, foster understanding and result in better outcomes for people with mental distress who interact with them; and improvements to mental health and suicide prevention support while on remand/in prison.

Alternative crisis prevention and management approaches and models

"We know...that risk...can be managed outside of the psychiatric environment, outside of clinical services, and it can be done really well" (Participant at tāngata whai ora hui)

"I was almost stuck in the cycle for about 10 years where I [was] medicated to death against my will it literally nearly did cost me my life on at least two occasions I can think of and...the thing that kinda helped pull me out of that cycle was when I first went to [a service] which was a peer lead youth alternative and that really was the beginning of me starting to break that

cycle ...for me peer lead acute alternatives instead of just going straight to an inpatient unit would be helpful." (Participant at tāngata whai ora hui)

The recent WHO [report](#) (2021) presents international examples of different ways in which crisis services can provide effective care and support and avoid compulsion and coercion, including assisting people to overcome their crisis at home with support from a multi-disciplinary team and delivering care and support in respite centres.²⁷ Common elements of these successful services include communication and dialogue, informed consent, peer involvement, being centred in the community and are well connected to other community resources and flexibility in the support provided.

These models were also put forward in our discussions with tāngata whai ora. They suggested well connected and resourced supports and services in the community that are multi-disciplinary and/or peer-led, recovery focused and provide wrap around support, could help to support people to stay well in the community. One person told us they had been unwell so many times it is clear what the warning signs are and they would like help – within community and primary mental health settings – within the two weeks of noticing these signs to change medication regimes and have daily monitoring and support to reduce the risk of inpatient admission.

Tāngata whai ora told us primary care and general medical practices could play more of a role in preventing and managing crisis and easing pressure on secondary services, including being able to prescribe medication or a change to medication. It was suggested a case worker connected to Health Coaches and Health Improvement Practitioners and based in GP practices could support tāngata whai ora in the community, much like the role of case workers in community mental health services.

Whānau also noted the role they play in supporting their loved one in crisis.

"When someone [is] first experiencing different reality and [is] alarmed about how they are it is important the family is included in the initial time. The family can provide rich background to services. No one knows you... [it is] important to have family or friends to help support you and advocate for you throughout [the] system." (Participant at whānau hui)

We support calls for emergency departments to be designed and resourced to enable respectful, culturally appropriate and compassionate responses to people in mental health crisis. Emergency departments should be a safe space where people can be seen within a reasonable timeframe – long, uncertain waits in a crowded environment are unacceptable.²⁸

²⁷ WHO. (2021). Guidance on community mental health services: Promoting persons-centred and rights-based approaches.

²⁸ Australasian College for Emergency Medicine Communiqué. 7 June 2019. Mental health in Aotearoa New Zealand Emergency Department Summit.

Secondary mental health services

Community mental health

More options and support should be available to support transitioning between inpatient services and the community. This might help relieve pressure on inpatient beds while also offering intensive support outside of the inpatient setting, for example for those who are on a new medication regime. It will depend on the person, but increased options could include temporary accommodation and respite care, supported by the peer workforce and with a discharge plan developed between the person, whānau and their care team. The current waitlists for emergency or temporary housing and the prejudice faced by people with lived experience in the housing market continue to be barriers.²⁹

Tāngata whai ora and whānau expressed particular support for an increase in respite beds available for community mental health service users. They noted that in Auckland DHB there is a significant shortage. Whānau saw this as a helpful way to transition tāngata whai ora from inpatient settings to the community and whare. They saw potential with additional day unit respite services to provide treatment delivered by skilled clinicians (social workers, OTs and nurses) able to provide intensive support if needed and activities that are meaningful and provide social connection. It was felt this could provide meaningful connection and useful distractions for people after a suicide attempt.

Whānau we spoke to note the important role they play in the process of transitioning from inpatient care back into the community and home, and that they need easy to access and timely support from community mental health to do this, including information about how to respond and provide care to their whānau member.

"In order for whai ora to get the most out of life, it's making sure whānau have the resources to do that... making sure there is support around transitioning [in]to [the] community and whare." (Participant at whānau hui).

In-patient services:

Tāngata whai ora paint a clear picture about how specialist mental health services need to respond when a person is unwell. For example:

"When I went into hospital not long ago, in my room they had this huge picture of our moana... and I felt so safe... if you can have visuals in clinical services, that is really awesome." (Participant at tāngata whai ora hui)

"A non-compulsive environment should be a place where individuals are not coerced into treatment, where chemical and physical restraint are used as a last resort, where individuals can make good, fair decisions about their treatment and these decisions are respected by all clinicians. It should be a

²⁹ Pere, L., Gilbert, H., & Peterson, D. (2002). Issues paper 2: Discrimination in Housing. Mental Health Foundation of New Zealand: Auckland, New Zealand.

calmer environment and individuals would feel empowered about the decisions they are making for themselves. There would not be locks on the doors, people would feel safe and secure and re-traumatisation would not be occurring. Individuals and their treating team would work together to come up with treatment plans and these would be adhered to. There would be respect given to an individuals ideas and thoughts about their own treatment. Different techniques such as de-escalation and using low stimulus areas could be used to manage distress on a ward." (Lived experience correspondence).

"[I was in a service] ... I walked in there and they were like, cool as, we're in the office if you need us, there's the fridge, have something to eat, have a good night and we'll catch up in the morning...and even just giving someone that space or even the ability to just have a moe and when I wake up there's going to be someone there I can sit and talk to about what's going on what my options are." (Participant at tāngata whai ora hui).

Several tāngata whai ora talked about inpatient wards being completely redesigned with the safety of tāngata whai ora and staff.

"it's basically just a high tech prison, right, and in those high-tech prisons they'd build the high visibility fish bowl model...where the staff just get to sit on their arse, they can press a button to restrict your movement, they can press a button to restrict your water, to your room...that's not a therapeutic environment. That's a prison. And I think we've gone a long way backwards in terms of...building facilities like that...they need to be home environments, ..." (Participant at tāngata whai ora hui).

Tāngata whai ora and whānau want services and information that is culturally relevant to Māori and other cultures and including bi-cultural and holistic approaches that embraces many world views. They wanted services to normalise Maori as a 'way of being' and embrace and understand what being Māori means for whai ora.

"...the polar opposite of hospital treatment...to what we may need...as Māori is for rongoā to be normalized wherever we go. So, we're good with karakia, we're good with waiata...things like...getting in the garden, growing vegetables, becoming more sustainable with those kinds of things...you know engaging in romiromi and mirimiri and engaging in a lot of our cultural practices where its normalised so it's not a special event it's just something we do everyday...rather than having a model of care for Māori, more of an understanding of a way of being." (Participant in tāngata whai ora hui)

"I think my healing journey really began when I went to wānanga and our... teacher there he said it's OK for females to use a taiaha... and so we learnt...Māori martial arts and things like that and we spent time on a marae with other people. It was an incredibly healing experience to really embody my own sense of empowerment within myself...." (Participant in tāngata whai ora hui)

"Surround me with things that make me feel safe. Surround me with all my photos of my family. Having them around me in photos, and my tūpuna, and my marae, and things that I connect to. That would make me feel safe."
(Participant at tāngata whai ora hui)

"Whatever we do, we need to... ensure that Māori part is not only accepted by also influence, and supported and encouraged..." (Participant at tāngata whai ora hui)

Tāngata whai ora recommended changes to physical environments to support connection to self, culture, whānau and the taiao.

"Bring me home to my marae. Surround me with my people in my marae, and just let me sleep there..." (Participant at tāngata whai ora hui)

"Can we be surrounded by people that love us?" (Participant at tāngata whai ora hui)

"Even our environment has to be different. Rather than roses, let's put kūmarahou and pourere in the gardens... and then have somebody come and tell us about the stories of the trees and sit outside. That would be a totally different way of teaching and learning and connecting for us as Māori. I betcha things would improve." (Participant at tāngata whai ora hui)

Include in the spaces "greenery, running water..." (Participant at tāngata whai ora hui)

Balancing clinical approaches with meeting spiritual needs and wairua was a major theme for tāngata whai ora and whānau. As stated by Durie (2011) for many tāngata whai ora Māori, spiritual encounters with therapists can be more enlightening than scientific explanations about chemical imbalances or impaired impulse control. Normalising of matakite (seeing and hearing voices) is healing and empowering. This view was also support by tāngata whai ora Pākehā who said some people who are mentally unwell and hear voices, for example, are comfortable with this experience and "there should be room for this" (lived experience correspondence).

"if somebody could have helped me explore what does this mean for me as Māori or even how to identify being Māori because before that I didn't know what being Māori meant...I didn't hear voices until I was up in the bush one day planting out my crop and a voice next to me said you can't plant here...I know now...I definitely should not have been planting there....It basically was Tāne Mahuta telling me 'you can't plant here'. And I understand that now."
(Participant in tāngata whai ora hui)

"... another prominent person I remember was a lady I met at a retreat and she was Māori and in her community it's normal to hear things, see things, experience things and in fact that information is used in a beneficial way to support someone through healing or to acknowledge something so I really definitely think that there's something there that needs to happen in terms of acknowledging that for Māori and I don't think in current mental health settings

there's really a lot that happen in that space especially for people in in-patient units." (Participant in tāngata whai ora hui)

"Pākehā have totally ignored the spiritual side... they don't acknowledge the wairua, they won't acknowledge the matekite..." (Participant at tāngata whai ora hui)

"Having our kaumātua available to us and our tohunga... people who understand the wairua world... that's preventative." (Participant at tāngata whai ora hui)

"Wellbeing looks like uplifting wairua" (Participant at tāngata whai ora hui)

Cultural leaders, advisors and healers should be available in every service and included in multi-disciplinary team meetings. Currently, they are an after-thought, and it was felt that what is available now does not have sufficient authority to ally and address challenges for tāngata whai ora within inpatient units.

"The cultural branch the kuia and kaumātua do their best but being a single entity in a psychiatric dominated space, they don't have the autonomy, the flexibility to really awahi us in the way we need in those places" (Participant at tāngata whai ora hui)

"...the biggest issues I have is the cultural support they have in hospital they have no teeth as such they have no ability to push forward and challenge what's happening with the Drs you know..." (Participant at tāngata whai ora hui)

Recommendation 9: Set a legal mandate for the development and enactment of a plan, co-designed with tāngata whai ora and tāngata whenua, to implement key service development and practice changes that will enable the absolute minimisation of compulsory treatment and restraint over 10 years. We recommend an explicit commitment to change, specific actions with milestones, and an accountable entity that can drive change over time.

Recommendation 10: Legally mandate, where possible, service development and practice changes, such as requiring cultural, peer and clinical partnerships, support for wairuatanga, and include mana-enhancing care as a guiding principle in the new law to protect and enhance tāngata whai ora mana and dignity.

Recommendation 11: Ensure the Government's Service and Systems Framework and the Mental Health and Addiction Annex to the Health Plan is designed to respond to and support the changes needed for the elimination of seclusion and the absolute minimisation of compulsory treatment and restraint, and done so alongside tāngata whai ora and tāngata whenua.

Recommendation 12: Implement the actions and approach outlined in *Kia Manawanui Aotearoa* with a strong focus on mental wellbeing prevention and promotion. We have previously called for a rolling action plan with clear accountabilities and developed by April 2022, to ensure *Kia Manawanui Aotearoa* is implemented in a concrete and transparent way.

Recommendation 13: Progress action on the *He Tapu te Oranga o ia tanaga Suicide Prevention Strategy and Action Plan* and continue dialogue with the suicide prevention and postvention sectors on the implications for suicide of any new policy direction for mental health laws.

Recommendation 14: Implement *He Ara Oranga* recommendation 35 to carry out a broad national discussion of mental health risk and safety. Law and system changes will be a radical shift for some members of the public and whānau and the journey towards absolute minimisation of compulsory treatment and restraint must be supported with a significant and sustained programme of work to change perceptions of mental 'illness' and distress, understanding of risk, safety, and 'dangerousness', and the culture of prejudice and discrimination against people with experience of mental illness.

ⁱ For example:

Brophy et al. 2019. Community Treatment Orders and supported decision making. *Frontiers in Psychiatry*, 10, 414; Gooding et al, 2018; Barbui, C, Purgato, M, Abdulmalik, J, Caldas-de-

Almeida, JM, Eaton, J, Gureje, O, Hanlon, C, Nosè, M, Ostuzzi, G and Saraceno, B (2020) Efficacy of interventions to reduce coercive treatment in mental health services: umbrella review of randomised evidence. *The British Journal of Psychiatry*, 1–11. doi: 10.1192/bjp.2020.144

Poremski. D., Alexander, M., Fang, T., Ong, S., Su, A., Fung, D., & Chua, H. (2010). Psychiatric Advanced Directives and their relevance to improving psychiatric care in Asian Countries. *Asia-Pacific Psychiatry*. 12(1).

Tinland, A., Leclerc, L., Loubiere, S., Mougeot, F., & Greacen, T. (2019). Psychiatric advanced directives for people with schizophrenia, bipolar 1 disorders or schizoaffective disorders. *BMC Psychiatry, BioMed Central*. 19 (1).

De Jong, M., Kamperman, A., Oorschot, M., Priebe, S., Bramer, W., van de Sande, R., van Gool, A., & Mulder, C. (2016). Interventions to reduce compulsory psychiatric admissions. *Jama Psychiatry*, 73 (7), 657–664.

ⁱⁱ A study of people with schizophrenia showed they were 14 times more likely to be victims of crime than perpetrators. (Brekke et al., 2001)

People with SMI [‘serious mental illness’] are six times more likely to experience victimization through recent domestic or sexual violence than the general population. (Khalifeh et al., 2016)

People with ‘severe mental illness’ are between 2.3 to 140.4 times more likely to experience victimization than people in the general population. (Maniglio, 2009)

Substance abuse is far more of a risk factor for violence than mental illness. Where mental illness and substance abuse co-occur, prevalence goes up. (Steadman et al., 1998)

In order to prevent one stranger homicide, 35,000 people with schizophrenia judged to be at high risk of violence would need to be detained. (Large et al., 2011)

The large majority of people with ‘mental illness’ do not engage in violence against others, and most violence is caused by factors (e.g., substance abuse) other than ‘mental illness’. (McGinty et al., 2014)

Only about 5% of violence is attributable to ‘mental illness’. (Ahonen, Loeber & Brent, 2017)