Mental Health Foundation
mauri tū, mauri ora
OF NEW ZEALAND

Submission from the Mental Health Foundation of New Zealand on the Mental Health Bill

Submitted to the Health Committee

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Who we are

The Mental Health Foundation of New Zealand (the MHF) is a leading mental health and wellbeing charity striving for a society where all people flourish. Our mission is to build an Aotearoa free from discrimination, where everyone can experience mauri ora or positive mental health and wellbeing.

We work towards this by:

- actioning our commitment as a Te Tiriti o Waitangi partner
- giving people tools and encouragement to look after their own mental health, and support others
- advocating for social conditions, policies and services that prevent the drivers of mental distress (such as racism, poverty, discrimination and trauma), reduce inequities, and lift the mental health and wellbeing of all people in Aotearoa.

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Executive summary

Tuia te rangi e tū nei
Tuia te papa e takoto nei
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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 Hauora Hinengaro.

The MHF's vision is for a mental health and wellbeing system that helps people recover and flourish long term – where everybody has what they need to thrive, communities support and protect mental wellbeing, and people have equitable access to care that respects their mana, dignity, rangatiratanga and self-determination. In this system, people experiencing mental distress would get the care and support they want without the use of coercion, traumatising and dehumanising practices, and heavy medicalisation to force compliance.

Overall, the MHF supports the Mental Health Bill (the Bill), but it does not get us as close to this vision as we had hoped.

Our key concerns and recommendations are as follows:

New legislation will not be transformative on its own and must be supported by changes in practice, service structures, resourcing and workforce development. To support the successful implementation of the Bill, we recommend the Health Committee (the Committee) direct the Ministry of Health | Manatū Hauora (the Ministry) and Health New Zealand | Te Whatu Ora to clearly demonstrate how and when "the system" will support the fundamental shifts needed to achieve a reduction in compulsory mental health care, and to prepare and publish a detailed implementation plan.

We recommend the Bill reference the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and that it be divided into separate civil and forensic/restricted pathways, to allow for the future merging of civil compulsory treatment processes into a "generic" capacity law (which is now being considered by the Law Commission). A general framework for protecting the rights of people with affected decision-making by any cause (including but not limited to mental distress) would align more closely with the CRPD, make capacity assessments easier and support positive shifts in social attitudes that people experiencing significant mental distress are not innately violent or dangerous.

The Bill's provisions for Te Tiriti o Waitangi need to be significantly strengthened, including with a dedicated directive that the Bill will be interpreted and administered to give effect to Te Tiriti o Waitangi, and by directly referencing the articles or principles of Te Tiriti o Waitangi and how the law will give effect to them.

The Bill needs to better provide for mental health equity for Māori and allow for tino rangatiratanga, including by embedding collaborative decision-making processes, adding an actionable commitment to reduce unacceptably high rates of solitary confinement and other restrictive practices for Māori, and by expanding the number of processes that entail hapū and iwi involvement.

There is a significant risk that the Bill's aspirations to embed supported decision-making could either not be realised, or lead to bottlenecks in support and other unintended consequences in practice. To avoid this, the Bill needs to safeguard its decision-making supports with more proactive obligations, provide clarity of roles, and be supported by upfront investment, a sustained funding model, and infrastructure to support the delivery of the new supported decision-making roles, especially advocates.

The Bill needs to provide for a shift towards a collective care approach, where decision-making authority is held by services and supported by teams, rather than held by single practitioners. Sharing responsibility within multidisciplinary teams could help the mental health system avoid a culture of blame and resultant use of restrictive or defensive practices and provide flexibility where appointing responsible practitioners is challenged by workforce shortages.

The Bill needs to include a sunset clause for solitary confinement (seclusion), prohibiting its use after a specified time, such as within five to 10 years of the law coming into force. A legal time limit will act as a lever to force the necessary system, service, workforce and practice change and investment in staff and facilities now, not later. The Bill must state that solitary confinement is traumatic and harmful to everyone involved.

There are strong grounds to discontinue community mental health care orders in most cases. New Zealand's use of community compulsory treatment is unjustifiably high by international standards and rising, despite evidence it is only effective under very limited circumstances.

Consideration should be given for a tribunal-like process to determine applications for mental health care orders rather than the courts, and second and subsequent extensions to mental health care orders should be shortened to six months. The dynamics of court processes ultimately leave tāngata whaiora feeling powerless and like criminals, and a tribunal-like system with shared decision-making could provide the ability to work more promptly, flexibly and collaboratively.

The Bill should include more checks and balances for medications and treatments that carry significant risks. This must include the Director publishing up-to-date evidence briefs for electroconvulsive therapy (ECT), accessible national reporting of sedative use (chemical restraint) to ensure there is no increase from efforts to eliminate solitary confinement, and provision for better monitoring of side effects for medications (e.g., clozapine) in care planning arrangements.

The obligation on the Director-General of Health to review the policy and operation of the law every five years should be strengthened with a requirement for the Minister with responsibility for mental health to table the review report and respond to its recommendations (with timeframes for legislative and service improvements) in the House of Representatives within a reasonable timeframe after receiving the report. Sufficiently actioning this regular review will be an important mechanism to ensure this law can adapt and improve to provide a long-term positive impact and an Aotearoa with increasingly less compulsory care.

Mauri tū, mauri ora

Shaun Robinson
Chief Executive

Submission

Introduction and overarching comments

> What is the point of living if I don't have autonomy? If I don't have rights? If I can't do life on my terms? (Tangata whaiora, 2022)

The MHF welcomes the opportunity to submit on the Mental Health Bill.

This submission draws on decades of analysis, advocacy, and interactions within the mental health system, and is informed by our engagement with tāngata whaiora (people with lived experience of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act)) and their whānau – collected in hui in 2021, 2022, and from stories shared with us directly.

The MHF has long advocated for the absolute minimisation of compulsory mental health treatment in Aotearoa New Zealand. Alongside many others, our vision is for a mental health and wellbeing system that is far less focused on protecting against risks we cannot accurately predict, and far more focused on helping people recover and flourish long term, with care that respects their mana, dignity, rangatiratanga and self-determination.

As in our 2022 submission to the Ministry, the MHF sees a residual role for compulsory mental health treatment and restraint, limited to only very exceptional circumstances and for a very short period of time, for example for a person's safety or where someone experiences seriously impaired decision-making and, after exploring all options, it is not possible to establish their will and preferences. This should only occur within a system that upholds strict regulation and scrutiny of these cases to ensure that any restrictions on a person's rights are absolutely necessary, applied in the least restrictive manner and for the shortest time possible.

We acknowledge and recognise the commitment of clinical and support staff in providing care every day in the face of significant workload and resourcing pressures, and the commitment and progress being made to reduce restrictive practices across localities. We acknowledge the significant efforts made by successive governments to invest in mental wellbeing, including in primary mental health supports and alternative responses to mental health and suicidal crises. We also acknowledge the bipartisan commitment by successive governments to shepherd through the repeal and replacement of the Mental Health Act.

The MHF supports this Bill, although it does not go as far as we had hoped. Overall, the MHF supports this Bill. We support many of the new provisions, particularly those related to supporting and assisting people potentially subject to the legislation to understand and participate in decisions, express their decisions (including in advance), have their rights upheld, and have their whānau and loved ones involved in their care. We do believe this Bill, if administered effectively, will bring us closer to the safe, empowering legal framework for mental health care that we envision for Aotearoa New Zealand.

That said, the MHF is disappointed the Bill is not as transformative as initially envisaged in *He Ara Oranga*, the 2018 report of the Government Inquiry into Mental Health and Addiction. After over 30 years without review, many saw this repeal and replacement process as a once-in-a-generation opportunity to reimagine our response to people experiencing significant mental distress.

New legislation will not be transformative on its own – it must be supported by changes in practice, service structures, resourcing and workforce development. Less compulsion should not equate to less care. In attempting to reduce the use of compulsory mental health care, we are faced with the challenge of ensuring the full spectrum of voluntary mental health supports are available, adequate, reaching people earlier, and preventing situations from escalating to the point of coercion being used.

These matters sit outside this law, but they will affect the successful delivery of the Bill and its policy intent. The reality is that there are perverse incentives leading to New Zealand's current over-use of compulsory treatment, and these will persist in spite of this Bill being passed unless there is a dramatic shift in our mental health system and its resourcing, planning, workforce growth and development, and prevailing attitudes, and unless we invest in services that provide care and support to people earlier and in different ways. Government strategy and policy, particularly the new Mental Health and Wellbeing Strategy due in 2025, must clearly demonstrate how the "big picture" levers will directly support the shifts in compulsory mental health care this Bill is seeking to achieve.

Furthermore, the success of this Bill, and particularly the crucial new supported decision-making processes and roles (especially advocates), and the intention to eliminate solitary confinement, will be dependent on careful planning and significant resourcing. It will also be important for implementation to ideally be co-designed and co-produced alongside people with lived experience, including whānau Māori. Where possible, our submission identifies the most pressing practical implementation considerations (**Recommendation 1**).

To support the successful implementation of this Bill, we recommend the Committee:

- Direct the Ministry and Health New Zealand to clearly demonstrate how and when "the system" will support the fundamental shifts needed to achieve a reduction in compulsory mental health care, including through the 2025 Mental Health and Wellbeing Strategy (**Recommendation 2**).
- Direct the Ministry and Health New Zealand to prepare and publish a detailed implementation plan for the new Act to give government, Parliament and the public an assurance the system is prepared to administer the new law as intended (**Recommendation 3**).

We note that the above concerns were borne out in the implementation of mental health law reform in Victoria, Australia from 2014 to 2021. The Victorian Mental Health Act 2014 had also aspired to minimise the use and duration of compulsory treatment, support "family and carer involvement", and embed human rights and supported decision-making frameworks. It included principles such as that "people receiving mental health services should be assessed and treated in the least restrictive way" and sought to provide safeguards like "advance statements" and nominated persons (Royal Commission into Victoria's Mental Health System, 2021). However, these safeguards were reported to be "not well known or commonly used" in practice, and a 2019-2021 Royal Commission into Victoria's mental health system found that "an ineffective implementation strategy, combined with insufficient resourcing to support reforms" had hindered the realisation of the Mental Health Act's intent. One summary expressed that "the Act's (almost) six years of operation demonstrate that legislative reform is going to achieve little when the system that it is seeking to regulate is simply not equipped, not resourced and not structured to take the principles set down in the Act and translate them into day-to-day practices" (Royal Commission into Victoria's Mental Health System, 2021).

The law needs to be practical and easily interpreted by a range of audiences. This Bill is sizeable and complicated, and the most significant review of the Mental Health Act in over 30 years. It provides for some major shifts in practice, especially in relation to participation in decision-making.

We think this warrants a comprehensive programme of engagement with communities (such as lived experience and whānau networks) and the workforce about the changes, as soon as possible after the Bill is passed, in a range of accessible formats that are adequately disseminated/marketed for the best reach (**Recommendation 4**). Secondary legislation such as guidelines will be a vital part of this but should not be the only way that the changes are communicated. We suggest looking to other jurisdictions for inspiration (such as Victoria, Australia's *Mental Health and Wellbeing Act 2022 Handbook*) and building on (the limited range of) existing tools in Aotearoa New Zealand, such as Community Law's *Overview of the mental health laws* webpages and Te Pou's resources for people and their whānau and Mental Health Act e-learning modules to support the workforce.

A general legal framework protecting people with affected decision-making by any cause (including but not limited to mental distress) might be more consistent with the CRPD and the Law Commission's recommendations to improve the Protection of Personal Property Rights Act 1998. The Committee on the Rights of Persons with Disabilities considers the "involuntary detention of those with mental illness" discriminatory (Ministry of Health, 2016). A "generic" law, while still not completely consistent with the CRPD (because it still denies the right to legal capacity), would end discrimination on the grounds of mental disability.

Given the Law Commission review of adult decision-making capacity law already underway, which necessitates consideration of central issues relevant to all law concerning decision-making capacity, a fundamental question for the Health Committee to consider is whether a more coherent and consistent approach would be to develop "generic" legislation that protects human rights and promotes supported decision-making for people with affected decision-making capacity, regardless of the cause of impairment.

The rationale of a generalised approach includes:

- Mental distress-specific laws can perpetuate prejudice and discrimination, including by reinforcing the perception that people experiencing significant mental distress are inherently dangerous or less capable of making decisions.
- Encouraging a more comprehensive view of decision-making capacity, recognising that mental distress is just one of many factors that can influence it. This broader perspective could allow for the inclusion of supportive measures for all individuals with impaired decision-making capacity, such as family support, legal representation, or advocacy, without the potential biases that might be introduced by focusing exclusively on mental health.
- Creating consistency and simplicity in legal frameworks, which could ensure the same level of supports and processes are available to everyone and prevent confusion about which laws apply in different cases. This could also enable people with impaired decision-making due to mental distress to access processes for decision-making on matters outside of mental health care.
- Removing the impracticality of solely attributing a loss of decision-making capacity to mental distress, as opposed to neurocognitive issues, intellectual disability, or a combination of factors.

Recommendation 5: Divide the Bill into separate civil and forensic/restricted pathways to allow for the future merging of civil compulsory treatment processes into "generic" capacity legislation.

Note: The rest of this submission is structured in line with the order of clauses in the Bill.

Interpretation

> Language has power. Language can affect the care and support offered to someone in distress and can result in increased isolation and disconnection. Remember, we are still people. (Lived experience advisor, 2024)

The MHF is pleased much of the language in the Bill has been modernised, and some terms carrying negative connotations have been updated or removed. For example, we support the replacement of expressions such as "abnormal", "mentally disordered", "serious danger" and "suffering from a mental disorder". These phrases are highly stigmatising and reinforce misunderstanding, prejudice and discrimination around mental distress and illness.

"Patient" should be replaced with a term that better recognises people's humanity and dignity (**Recommendation 6**). We question the continued use of terms like "patient" in mental health settings in 2024 and beyond. For both those performing a function or duty or exercising a power under the law and those subject to compulsory treatment, language like "patient" can reinforce power imbalances and presume a paternalistic, top-down approach to care, where the person is an "object" of treatment or something it is *done to*, rather than a person with mana, agency and dignity, whom the care should be led by and centred on.

Uncollaborative care and discrimination within mental health services have both been described as barriers to recovery (Mental Health Commission, 1998; Te Hiringa Mahara, 2023), and tāngata whaiora have spoken about feeling marginalised and isolated by labels like "mental patient" (Ministry of Health, 2017), which perpetuate demeaning and deficit-based perspectives compared with language that is more "wellbeing- [and] potentials-focused, and mana-enhancing" (Russell, Levy and Cherrington, 2018). We suggest using a more humanising alternative to "patient" such as "person subject to compulsory care", "person under compulsory care", or "tangata whaiora" (as defined below).

The title of the Bill should be changed to reflect the Bill's scope and purpose more accurately. "Mental health" should not be used as a synonym for mental distress (or in this case impairment), as this contributes to misunderstandings about mental health as a fixed (negative) state as opposed to a positive asset everyone can cultivate and develop. The purpose of the Mental Health Bill is not to restore, grow or sustain mental health and wellbeing in a broad sense, but rather to establish a legislative framework for compulsory mental health care under very narrow circumstances. We recommend changing the title to reflect this, such as to the "Mental Distress (Compulsory Care) Bill" (**Recommendation 7**).

The use of the term "tāngata whaiora" in the Bill is inappropriate and inconsistent. "Tāngata whaiora" is a well-established term which translates to "people seeking wellness/wellbeing" (Opai and Severne, 2020). In the mental health and addiction field it is generally accepted to mean people seeking wellbeing when experiencing mental distress, addiction, and/or harm from gambling or substances (Te Hiringa Mahara, 2022a). It is also often used synonymously with "service users" or "consumers", although some find this usage to be inappropriate (Te Hiringa Mahara, 2022b).

In the Bill, "tāngata whaiora" seems to be mostly used as a plural form for the Bill's definition of "patient", even though it is defined in the Bill simply as "people with lived experience of mental distress". Apart from being stylistically inconsistent (why is the plural for "patient" not "patients", or the singular form of "tāngata whaiora" not "tangata whaiora"?), if "tāngata whaiora" in the Bill means "people subject to compulsory care" it should be clearly defined this way, and "tangata whaiora" should be used as its singular form. We also suggest including in the interpretation section the term's literal meaning (i.e., "people seeking wellness/wellbeing") and its common interpretation (i.e., to mean people seeking wellbeing when experiencing mental distress, addiction, and/or harm from gambling or substances), alongside the definition of the term in the context of the Bill. If the term "patient" is to be retained, we do not recommend using "tangata whaiora" as a synonym for "patient" or "tāngata whaiora" as its plural, as we believe this usage is misaligned with the term's person-centred essence (**Recommendation 8**).

"Tāngata mātau ā-wheako", which translates to "people with lived experience", is a term typically applied in the context of the consumer, peer support and lived experience (CPSLE) workforce (Te Pou, 2023) that could also be useful to consider for this Bill.

The fragmented use of other kupu Māori in the Bill is questionable. We note that "mana" is invoked in the provisions relating to Mental Health Review Tribunals and hui whaiora, where Mental Health Review Tribunals must be guided by "the need to… uphold the mana of parties involved and promote restorative practices" when reviewing applications and complaints (cl 171), and hui whaiora may be convened for the purpose of "support[ing] restorative practice to uphold the mana of all parties following the use of coercive practices" (cl 17). While we support these principles, we question why upholding mana has only been recognised as important in post hoc processes, rather than upfront. It would be appropriate, for example, for a requirement to protect and enhance mana to be included in the compulsory care principles and in care planning (**Recommendation 9**).

The caveats are too loose for some of the obligations under the Bill. Where the Bill qualifies an obligation with "if it is (reasonably) practicable", "wherever practicable" or "as practicable", this should be rephrased (to "unless it is not practicable", for example) to make the obligation paramount unless the circumstances do not allow (**Recommendation 10**).

Te Tiriti o Waitangi

> Yes, we have Te Tiriti, but your actions are not reflecting it… When you are using Te Tiriti, I want to actually see it in action… (Tangata whaiora, 2021)
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> 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 awhi us in the way we need in those places. (Tangata whaiora, 2021)

The Bill is more consistent with Te Tiriti o Waitangi than the current Mental Health Act. In general, the MHF supports the provisions listed in clause 5 that describe how the Bill will provide for the Crown's intention to give effect to the principles of Te Tiriti o Waitangi. These provisions will all somewhat enhance our compulsory mental health law's alignment with Te Tiriti o Waitangi and its articles and health care principles (as articulated in the Waitangi Tribunal's 2019 *Hauora* report).

However, clause 5 does not itself create an imperative for the Bill to give effect to Te Tiriti o Waitangi. The statement "the following provisions in this Act provide for the Crown's intention to give effect to the principles of Te Tiriti o Waitangi" does not appear to establish a positive obligation for the Crown to interpret and administer the Bill a way that gives effect to Te Tiriti o Waitangi, as we do not expect that an "intention to give effect to" amounts to a requirement. It is also unclear which of the principles are intended to be "given effect to" by the provisions listed, as none of the provisions directly reference the articles or principles, or Te Tiriti o Waitangi at all.

In our view, clause 5 is more accurately a summary of the various provisions in the Bill that relate to Māori, and while many of them are helpful and likely to allow for compulsory mental health care to be provided in a way that is more consistent with Te Tiriti o Waitangi, altogether they do not comprehensively recognise and provide for Te Tiriti o Waitangi and its principles. Given there are no other references to Te Tiriti o Waitangi in the Bill, we are concerned that there is no real imperative for the administration of the Bill, those performing duties or functions or exercising powers under it, and the compulsory mental health care system as a whole to comply with Te Tiriti o Waitangi.

We recommend adding a standalone clause requiring the Bill to give effect to Te Tiriti o Waitangi or amending clause 5 to create a stronger directive to this end, such as by adding a preliminary subsection that first establishes that the Bill shall be interpreted and administered as to give effect to the principles of Te Tiriti o Waitangi (**Recommendation 11**). We also recommend directly referencing the articles or principles of Te Tiriti o Waitangi in the Bill, and how the law will provide for them (**Recommendation 12**).

While we support "equity in mental health outcomes" being a purpose of the Bill, we are concerned by the focus on eliminating disparities as the primary definition and driver for mental health equity. "Reducing disparities", and even equitable "mental health outcomes" alone are not synonymous with equity, and do not "capture the urgency or active effort required by the Treaty principles of active protection and equity" (Waitangi Tribunal, 2023).

Te Tiriti o Waitangi's principles of equity and active protection require the Crown to not only reasonably ensure Māori do not suffer disparities, but also "actively inform itself of the occurrence of inequity", and "make every reasonable effort to eliminate barriers to services that may contribute to inequitable health outcomes". Equity also requires that culturally and medically responsive mainstream services and properly resourced and supported kaupapa Māori (or "by Māori, for Māori") health services are equitably maintained and available to Māori (Waitangi Tribunal, 2023).

We recommend clause 3(b) be strengthened to recognise the breadth of what is entailed by "mental health equity", including by amending the wording from "…by striving to eliminate mental health care disparities, in particular for Māori" to "…including by striving to eliminate mental health disparities, in particular for Māori" (**Recommendation 13**).

It is also unclear how the Bill will meaningfully achieve the purpose to "provide for compulsory mental health assessment and care in a manner that… improves equity in mental health outcomes" (cl 3(b)). There is nothing in the Bill to directly address the inequitable use of the Mental Health Act on Māori, or the higher rates and more prolonged use of restrictive practices used on Māori. According to the most recent public data available, Māori are:

- 3 times more likely to be subject to compulsory assessment or treatment than other ethnicities (Ministry of Health, 2024).
- 5.5 times more likely to be put in solitary confinement (seclusion) than non-Māori – and since 2009, the rate of solitary confinement has been increasing for Māori despite trending downwards in the general population.
- Secluded for longer periods than non-Māori on average.
- 2.9 times more likely to be subject to an indefinite community order than non-Māori, and 4.1 times more likely to be subject to an indefinite inpatient treatment order[1] (Ministry of Health, 2023).

We believe the Bill could more directly outline how the provision of compulsory care under this framework will "improve equity" and "eliminate mental health care disparities" for Māori, with particular attention to addressing the drivers of inequitable rates of compulsion and restrictive practices on Māori. These drivers are multifaceted and addressing them will include actions outside the scope of the Bill. **That said, we have several specific recommendations for how the Bill itself could better provide for equity, and Te Tiriti o Waitangi more generally**:

- Examinations and assessments to determine whether a person meets the compulsory care criteria should be conducted by multidisciplinary teams or rōpū whaiora, rather than single practitioners, and include Māori

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

practitioners if the person is Māori or if requested (and if such a practitioner is available). This carries both an element of cultural responsiveness as well as balancing the power held by single practitioners to unilaterally determine whether to disregard a person's human rights (**Recommendation 14**).

- We recommend that applications for mental health care orders are reviewed by Māori (ideally mana whenua), either in the Family Court framework provided for in the Bill, or via the tribunal framework recommended in this submission in the "Mental health care orders" section (**Recommendation 15**).
- The Bill should include a dedicated obligation to reduce the unacceptably high use of solitary confinement (seclusion) and other restrictive practices, restricted treatments and force on Māori (such as in clause 49 and 200 respectively), with corresponding practical actions that will give effect to this obligation. Provisions to this end could include, for example, a requirement to have kaumātua in every service, and 24-7 cultural support for tāngata whaiora, especially in contexts where solitary confinement (seclusion) is provided for. This has been acknowledged as a protective factor against the use of solitary confinement in mental health units on all tāngata whaiora, not just Māori (Te Aka Whai Ora, 2024) (**Recommendation 16**).
- Alongside whanaungatanga, the compulsory care principles should also support manaakitanga and wairuatanga (**Recommendation 17**).
- The holistic assessment in the care plan should recognise the strengths of whānau, hapū and iwi, either as its own subsection in clause 43(4)(a) or as part of clause 43(4)(a)(iv) (**Recommendation 18**).

To support the successful delivery of these additions as well as the provisions listed in clause 5, and give better effect to Te Tiriti o Waitangi and meet the Bill's purpose of "improving equity" overall, the implementation of the Bill will need to be supported by better resourcing of iwi and kaupapa Māori services and the Māori mental health workforce, and workable contracting arrangements, so that services and kaimahi have the capacity and flexibility to practice in accordance with tikanga and te ao Māori. This will need to address, for example, adequate staffing levels of kaimahi with cultural expertise needed for rōpū whaiora and to carry out the cultural considerations and holistic needs in accordance with tāngata whaiora's care plans and (potentially) their compulsory care directives. It would also require better resourcing for the mental health workforce as a whole, to allow the principle of whanaungatanga to be meaningfully achieved (i.e., understaffed, strained services are a barrier to building nurturing, respectful relationships with tāngata whaiora).

This will require specific attention, planning and resourcing, because at present, we know that:

- There are not enough kaimahi Māori to embed kaupapa Māori approaches in mainstream facilities, and there is a lot of pressure on the few kaimahi Māori to uphold kaupapa Māori approaches (Te Aka Whai Ora, 2024).
- There is an evidenced shortage of kaimahi Māori, particularly in clinical roles. In 2022, 11.8 percent of mental health inpatient nurses were Māori (Te Kaunihera Tapuhi o Aotearoa cited in Te Aka Whai Ora, 2024), less than the estimated proportion of the total population who are Māori (17.1 percent as at June 2024) (Statistics New Zealand, 2024). Data also show that the number of Māori nurses has been in decline since 2019, and the proportion of Māori in clinical roles is even smaller. In 2022, only 5.8 percent of clinical psychologists were Māori (Te Poari Mātai Hinengaro o Aotearoa cited in Te Aka Whai Ora, 2024).
- These staffing shortages are more striking when compared against the proportion of Māori accessing mental health services, which is 28.4 percent (and 39.6 percent of those subject to a compulsory treatment order in 2021/2022) (Ministry of Health, 2023).

Tino rangatiratanga and partnership for hapū and iwi as mana whenua are not adequately recognised and provided for in the Bill. Requiring expertise in tikanga and mātauranga Māori in the membership of Mental Health Review Tribunals and Forensic Patient Review Tribunals (cls 164(40(b) and 174(3)(b)) is a positive step to partly afford decision-making power to Māori in line with tino rangatiratanga and the principle of partnership. That said, in contexts where Māori are the minority (and/or where ultimate decision-making power rests with, for example, the responsible practitioner or other actor), tino rangatiratanga and partnership will be somewhat diluted. True partnership and tino rangatiratanga entail more than simply "participation" in decision-making, and enshrining tino rangatiratanga also requires not just affording decision-making authority to *Māori*, but to iwi and hapū who are mana whenua in their rohe – who will also have intimate familiarity with the health needs and community make up of their district.

The Bill makes very few explicit references to the roles and powers of hapū and iwi at present. We recommend more explicitly acknowledging which of the Bill's provisions might entail responsibilities for hapū and iwi, particularly in the "Tāngata whaiora rights and support" section (including the provisions for hui whaiora, advocates, and nominated persons) (**Recommendation 19**). We also recommend the Health Committee consider whether a person could be permitted to appoint more than one nominated person or a "nominated collective", to give better effect to tikanga Māori and collective decision-making (**Recommendation 20**).

We are concerned that the clause 6(1)(c)(iv) "supportive and responsive application" principle that "compulsory care should... recognise the importance and significance of the person's ties to their family, whānau, hapū, iwi, and family group, and the contribution these ties make to well-being" has diluted the equivalent provision in the current Mental Health Act, as it is now qualified by the statement "to the extent that is reasonably practicable".

Compulsory care matters

> I would like ... 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. (Tangata whaiora, 2021)

Compulsory care principles

> ...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. (Tangata whaiora, 2021)

We note that other provisions in the Bill may override or could be inconsistent with the principles, particularly given the principles only apply when reasonably practicable and when having regard to all circumstances. We are concerned this may make the principles ineffective.

We are concerned the criteria relating to serious harm to self or others (cl 7(2)) may be given more weight in compulsory care decisions over the principle of "therapeutic purpose" and protecting, promoting and improving a person's mental health. We note the UK's Mental Health Bill includes in its criteria for detention and community treatment the grounds that appropriate treatment is available, meaning there must be a reasonable prospect of alleviating or preventing the deterioration of the disorder/symptoms (Mental Health Bill 2024 (UK), cls 5-6), and the Ministry's Regulatory Impact Statement notes the preferred option (and in fact all three options considered) for compulsory treatment criteria included a criterion that the person must be able to benefit from mental health care or treatment, suggesting it should be given equal weight alongside assessing risk of harm.

Recommendation 21: Seek expert advice on drafting options to give legal and practical effect to the human rights policy intent of the principles.

The principle of "least restrictive application" (particularly its suggestion of "preference for voluntary options"), and indeed all the compulsory care principles, **would be served by establishing a better crisis response and acute support system**. "Least restrictive application" is already an implicit principle of the current Mental Health Act (as noted for example in the *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992 guidelines*), and although making this explicit and expanding on it is a positive change, we question how this principle will be met without additional system capacity. It is difficult to give effect to a principle that requires voluntary options to be "actively offered and preferred" when such options are unavailable.

The "supportive and responsive application" principle should support holistic approaches and the unique needs of women and gender-diverse people. One of the dominant themes we continually hear from tāngata whaiora is the desire for a holistic approach to healing and care from the mental health services they interact with, including compulsory care.

Recommendation 22: To support and reinforce this, we recommend the "supportive and responsive application" principle (cl 6(c)(ii)) specifically recognise people's *holistic* needs.

We've heard of women experiencing postpartum depression or psychosis who have been separated from their newborn babies under a compulsory treatment order (because there was no voluntary care option) and placed into mixed-gender wards, which they say was traumatic, unsafe, and unsupportive. Some women do not seek help for fear of their babies and children being removed from their care.

We also understand women and gender-diverse people are at greater risk of gender-based violence in mental health units (typically due to the combined effects of strong medications and acute mental distress) (Jenkin et al., 2022).

While many solutions sit outside of the law (e.g., more Mother and Baby units, safe spaces on wards and clinical staff that identify as, and understand the experience of being, gender-diverse), legal recognition will drive the provision of compassionate care and associated resources that affirm identity, gender and sexuality and keep people safe. We note Victoria, Australia's Mental Health and Wellbeing Act 2022 (s 26) includes an extensive gender safety principle that acknowledges and requires services to give consideration to specific safety needs or concerns based on gender.

Recommendation 23: We recommend the "supportive and responsive application" principle recognise and support the unique needs and experiences of women and gender-diverse people.

Compulsory care criteria

> I just think that if we're determining capacity, like really? Based off of a twenty-minute conversation… textbook answers decide what's good for you? I just don't agree with it. (Tangata whaiora, 2021)

> There is an illusion that locking people up results in safety. (Lived experience advisor, 2024)

We welcome the less stigmatising language used compared to the current Act, such as that the threshold is no longer related to "serious danger".

The threshold for compulsory mental health care appears to be higher, but it is not clear if this will result in less compulsion in practice. The narrowing of the compulsory care criteria to include lack of decision-making capacity due to seriously impaired mental health is a significant change from the current Mental Health Act. However, as noted in the Regulatory Impact Statement for the Bill, "there is no New Zealand literature suggesting that a large number of people with capacity are made subject to compulsory treatment" and international data on this is ambiguous. Where capacity-based mental health legislation was introduced in Norway, for example, no decrease in the use or duration of compulsory mental health treatment was observed (Hoyer et al., 2022).

Moving to capacity-based criteria seems to reflect global trends in legislation for involuntary detention due to mental distress and is more consistent with the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SACAT). However, if the additional requirement for seriously impaired mental health to cause the person to lack decision-making capacity does not confer any benefits or effects (such as to reduce the use of compulsory care), will this be needlessly creating another process for people being assessed under the law to endure, and another requirement for the stretched workforce to meet?

The Bill's retention of an assessment of risk (i.e., that the seriously impaired mental health "is likely to cause in the near future, in the absence of care, serious adverse effects") remains problematic. The assessment of risk or "dangerousness" is a carry-over from the current Act, and while it is a common element across mental health laws in other jurisdictions, it is problematic for several reasons:

- Risk is notoriously hard to predict (World Health Organization and the United Nations, 2023).
- With a few exceptions, it is ethically questionable to deny people liberty on the possibility they may cause harm (World Health Organization and the United Nations, 2023).
- There is limited evidence to support the success of coercion in reducing the risk of self-harm or protecting the public (Funk and Drew, 2019; Kersting et al., 2019; Nelstrop et al., 2006), and there is little evidence that risk assessment tools and coercive mental health treatment prevent suicide (Handley et al., 2018; Large, 2018).

The Ministry notes that for "most people with severe mental illness, 'violence is no more predictable in them than in those without mental illness, nor is the propensity [tendency] for violence clearly more "treatable" in them' (Szmukler 2019). In the absence of alcohol, substance use or an antisocial personality, the risk is only slightly raised (Large et al 2011; Szmukler and Bach 2015; Varshney et al 2015). This compounds the issue of risk assessment and the linkage with mental disorder" (Ministry of Health, 2021).

The Committee may wish to seek assurances about the implications of clauses 8 and 9 (meaning of "seriously impaired mental health" and "capacity to make decisions about mental health care"). The list of exclusions for what can solely form the basis of "seriously impaired mental health" is robust. That lack of capacity cannot be based solely on the refusal of mental health care is particularly significant, as we have heard from tāngata whaiora that this can be a major driver for putting a person under the Mental Health Act currently.

The MHF suggests the Committee seek assurances on the following points:

- How the influence of treatments on decision-making capacity will be accounted for. Strong sedating medication, for example, can have a significant effect on a person's ability to retain information, make decisions and at times even have basic communication abilities. This could be acknowledged in clause 9(4) (things a person cannot be considered to lack capacity to make decisions about mental health care solely on the basis of).
- Actively ruling out "seriously impaired mental health" deriving from physical illness. We note this is in the exclusion list at clause 8(2)(k), but expect this will need to be ruled out as a condition of assessment (and noted in cls 43, 58, and 62, for example).
- The meaning and effect of "intermittent" in relation to an impairment in mental functioning and "on a sustained basis" in respect of decision-making capacity. Could a person remain under compulsion even if they regain capacity or mental functioning, on the basis that this recovery is "intermittent"?
- The practical impossibility of attributing a loss in decision-making capacity to mental distress alone (rather than a combination of factors), as required by clause 7(1)(c) and noted in our overarching comments.

Tāngata whaiora rights and support

> But in regards to making people compliant and making people live the way they do and that, that's not about our tino rangatiratanga. The thing for me is about supporting them to become self-determining. Supporting tāngata to make their own mistakes. And the thing is, we are gonna make mistakes no matter what we do. But, we need to be able to be involved in those choices. (Tangata whaiora, 2021)

The MHF has an established position that people experiencing mental distress should have legally protected access to supported decision-making processes. We have continually advocated for the mental health system to embed a variety of supported decision-making models (from informal supports, to more structured and legally mandated mechanisms) that better enable tāngata whaiora and their whānau to make decisions about their mental health care and recovery, including by allowing for and promoting collective decision-making approaches informed by tikanga and te ao Māori. The reasons for our position include:

- In contrast to "substituted decision-making",[2] supported decision-making is more aligned with the CRPD, as well as clinical best practice and person-centred care (Te Aka Matua o te Ture, 2024).
- Supported decision-making tools have been shown to benefit tāngata whaiora, including by reducing the use of coercion in mental health services, enhancing people's wellbeing, self-esteem, and ability to communicate and make decisions over time, improving treatment outcomes and satisfaction with services, reducing fear and anxiety associated with certain treatments or medications, and increasing treatment adherence.
- Effective supported decision-making will significantly prevent the use of seclusion and other restrictive practices (Brophy et al., n.d.; Tinland et al.,

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[2] By which we mean arrangements where someone makes a decision for another person in their "best interests" without providing support to establish their will and preferences in respect of that decision.

2022; Dawson et al., 2021; Barbui et al., 2020; Brophy et al., 2019; Tinland et al., 2019; Lai et al., 2019; De Jong et al., 2016; Premski et al., 2010; Delman et al., 2015).

Overall, we strongly support the new supported decision-making regime established by the Bill, but are concerned about how it will be brought to life successfully. We note several potential barriers to effective implementation of the supported decision-making regime, including that:

- **Some of the provisions are insufficiently proactive, with numerous loopholes, "opt-outs" or caveats that could dilute their potency or rate of use in practice**. For example, tāngata whaiora have the ability to make compulsory care directives, and the directives carry significant weight, but there are no clear accompanying requirements as to whether and when tāngata whaiora should be informed of their ability to make a directive – and the provisions for nominated persons are similar. As another example, while hui whaiora are required if requested by tāngata whaiora, again there is no parallel requirement for tāngata to be informed of their right to request one. There are also several qualifiers such as "to the maximum degree appropriate", "if reasonable", "if practical" and "if reasonably practicable" which if interpreted liberally could undermine the Bill's safeguards for supported decision-making. At least historically there was confusion under the current Mental Health Act about what qualifies as "reasonably practicable" when it comes to consulting whānau (with resulting low rates of consultation) – there is a risk the qualifiers here could have similar consequences.
- **There is a lack of clarity in how the roles (especially advocates and independent support persons) are delineated, and how they and other safeguards (such as nominated persons and compulsory care directives) intersect and/or override each other.**

In our view, for the Part 2 provisions to be truly effective and in line with the principle of "supportive and responsive application", they need to be available to tāngata whaiora at all times. In the context of the barriers outlined above and existing shortages in resourcing and staffing, we think there is a significant risk that the Bill's aspirations to better embed supported decision-making could either not be realised, or lead to bottlenecks in support and other unintended consequences in practice.

To support effective implementation of the new supported decision-making provisions, we recommend:

- The implementation plan for the new Act (noted at **Recommendation 3**) address adequate support for the workforce to change practices, including by endorsing increased resourcing and growth, coordinating system-wide leadership to drive change, as well as adequate training and guidance for the workforce and other practical essentials to ensure decision-making supports are effective and available at all times (**Recommendation 24**). If useful, we have appended to this submission an outline of these "practical essentials" (at page 58).
- There is upfront investment, a sustained funding model, and infrastructure development to support the delivery of the supported decision-making roles, especially advocates (which we address in the "Advocate" section below). This should include consideration of the potential contribution of, and supporting infrastructure for, the tāngata mātau ā-wheako or CPSLE workforce (**Recommendation 25**).
- The supported decision-making roles are better delineated in the Bill, as noted in more detail in the "Advocate" section below (**Recommendation 26**).
- Making the Part 2 provisions more proactive where possible, with sufficient obligations for people administering the Act to inform tāngata whaiora about, and provide, decision-making supports (such as advocates) at specific points in the compulsory care process (and repeatedly) (**Recommendation 27**).

Provisions should be available to tāngata whaiora receiving voluntary care, too. We recommend that steps are taken to ensure the provisions under Part 2 of the Bill are also made available to people accessing voluntary mental health care in hospital (**Recommendation 28**). On a practical level, this could also facilitate the awareness and use of things like compulsory care directives and nominated persons, for example.

Compulsory care directives

> 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…" (Tangata whaiora, 2021)
>
> I'd like to see the focus change from an illness industry to a healing industry… where the clients are in charge of their own healing and they work in conjunction with the professionals. They plot their own path – what is healing for me? What is healing for you? (Tangata whaiora, 2021)

The MHF supports the introduction of legally binding advance directives in the Bill. Pre-planning arrangements have been identified as a meaningful supported decision-making tool for tāngata whaiora (Gordon et al., 2022), and the benefits of advance directives are well-evidenced. They have been shown, for example, to enhance people's recovery, minimise the use of coercive practices such as involuntary hospital admissions and solitary confinement (seclusion), and also reduce people's fear and anxiety associated with certain medications and treatments (Brophy et al., n.d.; Tinland et al., 2022; Dawson et al., 2021; Barbui, et al., 2020; Brophy et al., 2019; Tinland et al., 2019; Lai et al., 2019; De Jong et al., 2016; Premski et al., 2010; Delman et al., 2015).

We question whether there are sufficient obligations for people administering the Act to proactively inform tāngata whaiora and whānau about compulsory care directives, and provide them in a supportive manner. As noted in our comments on the supported decision-making provisions more generally, it is not clear whether and when it is required for tāngata whaiora to be informed about their ability to make a directive, or what constitutes "reasonable assistance" to make or revoke one. The Bill only talks of the process to make directives (i.e., when identified as wanted by the person), and where they apply, but not of when they should be offered and by whom. We are concerned this could limit their uptake and utility.

For advance directives to be effective, they need to be completed in a supportive manner and with clear understanding of the situations that could invoke a compulsory care directive and the options available (RANZCP Victorian Branch, 2021). Ideally, compulsory care directives would be developed outside of compulsory care frameworks (i.e., in primary and voluntary secondary care) so they can be effective at preventing the need for compulsory care in the first place.

Recommendation 29: Primary, secondary and other voluntary mental health services should have a duty to inform people of their right to make a compulsory care directive, provide information about them, and ensure tāngata whaiora and their network are adequately supported to make or update one.

Recommendation 30: The Bill, or its secondary legislation, should specify the points (in the compulsory assessment and care process, such as upon release from compulsory status) at which tāngata whaiora are required to be informed of their right to make a compulsory care directive, and can be supported to make, update or revoke one.

Recommendation 31: Investigate the practicability of limiting who can be consulted about, and who can give assistance to make or revoke compulsory care directives to "mental health practitioners" only. We are concerned this could lead to bottlenecks, and the tāngata mātau ā-wheako or CPSLE workforce for example could also be ideally placed to walk tāngata whaiora through these processes.

Recommendation 32: Change the wording, at clause 12, from "preferences [i.e., regarding how and where method of care is provided, and involvement of support network] must be given effect to, to the extent that is reasonable/practicable" to "unless not reasonable/practicable".

Recommendation 33: Clarify the consequences of going against a compulsory care directive, and how this will be monitored. It is noted that "care must be provided unless section 47 applies", and if it does apply there is a duty to report. However, it is not clear what happens following reporting. It could be noted here, for example, that a hui whaiora should be held after a compulsory care directive has been breached.

We suggest the Committee consider all possible measures to ensure compulsory care directives are well protected, accessible and useful for tāngata whaiora. These measures could include, for example:

- Ensuring there is a central mechanism to store, update, review and share compulsory care directives nationally.
- Allowing compulsory care directives to be provided in a range of format options, such as audio or video recording as well as in writing.
- Allowing compulsory care directives to be developed in a range of accessible and comfortable settings, such as in a person's home or community if wanted.
- Clarifying (such as in guidelines) that the meaning of "information relating to the maker's affairs" includes childcare arrangements. Tāngata whaiora have told us they worry about not being able to decide on childcare arrangements if they are subjected to compulsory care away from home, with some saying the fear and uncertainty about their children's wellbeing makes them feel reluctant to seek help.

Hui whaiora

> There needs 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. (Lived experience correspondence)

In general, the MHF supports the clause 17 provisions for hui whaiora. The provisions for hui whaiora align well with the principles of whanaungatanga and relating well to others, and recognise the supportive role of a person's extended whānau and loved ones.

Tāngata whaiora want restorative practices, but they need to be genuinely restorative, and well supported within service infrastructure. The purpose to "support restorative practice to uphold the mana of all parties following use of coercive practices" is positive in principle. Restorative practices have been acknowledged by tāngata whaiora and some working in the mental health sector as a key vehicle to encourage understanding, healing and learning after an infringement of rights (Roguski and Chauvel, 2022). Coordinating these hui, and conducing them well, may be administratively challenging. Again, there will need to be workforce growth, adequate training and practice changes for hui whaiora to be implemented and maintained effectively and efficiently.

The processes for hui whaiora could draw from the Open Dialogue approach, and should aim to be person-centred first and foremost. Hui whaiora (together with care planning) appear to have commonalities with the Open Dialogue approach to care, in which transparency and relationships are key tenets. A truly Open Dialogue aligned process would require that no decisions about the person in distress are made outside of network hui, and within those settings, clinicians would be expected to openly discuss their observations. This is expected to rebalance power dynamics away from clinicians and facilitate "doing with, not to" and whanaungatanga (Stockman, 2024).

Recommendation 34: Consider lessons from Open Dialogue to inform hui whaiora and care planning processes.

Recommendation 35: Tāngata whaiora should have the option to opt out of hui whaiora if they wish. Currently they "must" happen if no compulsory care directive or nominated person is in place. Supported decision-making processes should always be voluntary.

Recommendation 36: Notes from hui whaiora should be recorded and agreed to collaboratively.

Support network

> 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. (Tangata whaiora, 2021)

The MHF supports the provisions for a person's support network, although it is currently only relevant to the processes for hui whaiora, care planning, rights, and the first assessment.

Recommendation 37: Consider strengthening the support network so it is involved more often and/or in more processes under the Bill.

Recommendation 38: Clause 18 should explicitly note that a person's support network can include roles for iwi, hapū and kaumātua.

Nominated person

The MHF recommends:

- Secondary legislation or other supporting material provide adequate guidance for the nominated person and others in the support network (such as whānau) to fulfil their roles in accordance with supported decision-making principles, which should include, for example, how to handle disagreements and key concepts such as the "dignity of risk". This will be especially important for nominated persons who may have previously assumed a substituted decision-making role for the tangata whaiora – it is important they are acting on the person's will and preferences and not their "best interests" (**Recommendation 39**).
- Clarifying (in the Bill or in secondary legislation), the scope of the authority for the nominated person (or how this will be established in each case), including the decisions and/or decision-making processes nominated persons have dominion over, how nominated persons and compulsory care directives intersect or override each other, and what checks and balances will be provided to ensure nominated persons do not act outside their scope, or will be triggered if nominated persons are found to be acting against a person's will and preferences (**Recommendation 40**). We acknowledge clause 22 provides for Mental Health Review Tribunals to revoke a nominated person appointment if "not in the best interests of the patient" but this may not cover acting against a person's will and preferences.
- As noted in the section of this submission on Te Tiriti o Waitangi, the Health Committee should consider whether a person could be permitted to appoint more than one nominated person or a "nominated collective", to give better

effect to tikanga Māori and collective decision-making (Elder, 2019) (**Recommendation 20**).

Independent support person

As noted above, we observe a lack of clarity in how the Bill's supported decision-making roles (especially advocates and independent support persons) are delineated and recommend this is addressed in the Bill. We address this point in more detail in the next section.

Advocate

> The lawyers coming in and just going "here's a lawyer" like five minutes or even a minute before the meeting. That happens so often. (Tangata whaiora, 2021)

The MHF is strongly in support of a comprehensive advocacy framework for compulsory mental health care. Provision of advocacy support is an important check on a system that overwhelmingly operates behind closed doors, and that has a dark history of discrimination, abuse and neglect arising from, in part, a lack of such safeguards as advocates.[3]

The potential caveats for advocates in the Bill, and lack of supportive infrastructure, could compromise their effectiveness as a safeguard for tāngata whaiora rights. While clause 24 provides that Health New Zealand "must ensure a reasonable number of advocates are available", this leaves a lot of room for interpretation on "a reasonable number" and there do not appear to be any obligations or responsibilities for responsible practitioners or other mental health practitioners to assist tāngata whaiora in procuring an advocate. Section 70 of the current Mental Health Act entitles tāngata whaiora to legal advice, however there is no obligation for mental health services to provide lawyers, and there are barriers to accessing legal aid. We are concerned the provisions for advocates could be similarly neutralised in practice.

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[3] As documented, for example, in *Whanaketia*, the final report of the Abuse in Care Royal Commission of Inquiry.

We are also interested in how advocates will be "promoted" to tāngata whaiora. In our view, there should be specific points along the examination, assessment and care process at which people are required to be informed (and reminded) of the functions and duties of advocates and their entitlement to them. This should also be supported by information provided in voluntary mental health care settings.

Recommendation 41: Explore the appropriateness of an "opt-out" approach to access to advocates as seen in Victoria, Australia, so the onus is not on the individual to seek out advocacy services.

Recommendation 42: The powers of advocates, processes where they can be engaged, and practical mechanisms for procuring them should be made clearer.

Recommendation 43: Tāngata whaiora should have 24-7 access to advocates and this should be enshrined in the Bill. For example, clause 24(3) could be amended to read "Health New Zealand must ensure a reasonable number of advocates are available, such that all patients can access an advocate at any time".

We consider that the following implementation issues will need to be addressed:

- The development of advocate roles nationally will require upfront investment and a sustained funding model, and infrastructure development to support national coordination, recruitment/selection, oversight, education, training, supervision and support. Operational insights might be sought from the HDC-contracted independent National Advocacy Trust.
- Advocates will need to be funded and supported to be available within services but also "roaming" across secondary mental health settings in communities.
- Having advocates maintain a degree of independence from services, while their roles are funded through Health New Zealand.

Recommendation 44: Mandate in the Bill a Principal Advocate role to provide stewardship for advocate roles, with responsibilities to provide national coordination and leadership, and to support the development of guidelines, a code of practice, training and other infrastructure needed to support and maintain the successful roll-out of a new national advocacy workforce.

Whānau

> Please talk to their loved ones [and] hear their journey because everyone is different, everyone needs different kinds of support. (Whānau lived experience correspondence, 2022)

We recommend the Bill include a duty to provide access to support, information and advocacy for family and whānau, with parallel allocation of resources and funding to support its implementation (**Recommendation 45**).

Rights

> [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...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..." (Tangata whaiora, 2021)

Overall, we support the modernising and strengthening of rights in the Bill. In particular, it is positive to see relevant rights extended to those receiving voluntary care in inpatient units to allow them to access the complaints process under the law (cl 25), and the increased acknowledgement and protections for children and young people (cl 38). Other improvements we support include:

- The right to medical and other health care explicitly including physical health needs and the requirement on practitioners to take reasonable steps to ensure that suitable care is provided (cl 23). This is positive in light of physical health inequity concerns.
- That a person must be informed about their rights in the presence of their support network or others, which may include whānau/family. This will help

support people to understand their rights and have somebody to discuss their rights with or ask questions and gain further clarification.

Recommendations:

- Reference the CRPD in the Bill to serve as a guide for the interpretation of specific provisions by courts and statutory roles and to ensure interpretations are consistent with international principles (e.g., the right to equal recognition before the law and to legal capacity) (**Recommendation 46**).
- Consider an extension to "General rights to information" (cl 26(2)) to require the responsible practitioner to be satisfied the person has understood their rights – and if not, all reasonable steps were taken to assist them to understand (**Recommendation 47**).
- "Right to respect for culture and identity" (cl 27) could explicitly include gender identity (**Recommendation 48**).
- Consider an additional right to access to peer support, unless it is not practicable to do so (e.g., in the event of local peer support services being unavailable) (**Recommendation 49**).

Complaints

We welcome the introduction of enhanced powers to allow district inspectors to report matters directly to the Director where they have not been satisfactorily addressed, and new principles to guide district inspectors in complaints investigations, particularly to promote restorative practices. We note that the principle of fairness, which suggests a rigorous process, may conflict with the principles of timeliness and efficiency. It would be useful to understand, and seek assurances about, how district inspectors might give weight to these different principles through the complaints process.

Implementation issues to be addressed:

- Increase visibility and understanding of the role of district inspectors, which is not well understood by clinicians, tāngata whaiora, or families and whānau at present.

- Ensure appropriate appointment processes, resourcing and support for advisors with expertise in matters involving tāngata whaiora Māori (as established at clause 40).

Compulsory care requirements

> We need more lived experience in those clinical services (Tangata whaiora, 2021)

Rōpū whaiora

> In order to be able to be in a position to make a decision, the right people need to be in the room with us. It's not just about putting into the Act that people can make decisions, actually there might be different people we need involved in our care at the time you are trying to ask [us] what treatment... we want... (Tangata whaiora, 2022)

> When I think about the decisions being taken away from me, part of the problem is all of the options weren't given to me. What if these medications had serious side effects and I didn't know? (Tangata whaiora, 2022)

The MHF understands that multidisciplinary care teams are already best practice, but we are pleased to see this approach enshrined in law in the form of rōpū whaiora. We strongly support legislating for a shift toward a collective care approach, which is more in line with the aspirations of tāngata whaiora, can better support a holistic approach to care and cultural responsiveness, and redistribute the power held by single practitioners to unilaterally determine whether and when to disregard a person's human rights. Sharing responsibility within multidisciplinary teams and services could help the mental health system avoid a culture of blame and resultant use of restrictive or defensive practices and provide flexibility where appointing responsible practitioners is challenged by workforce shortages. We appreciate the provisions for rōpū whaiora are embedding a more collaborative approach, which is positive, although primary decision-making power still rests with the responsible practitioner. Authorising services to hold the "responsible practitioner" function is something we would suggest is considered, either in this Bill or in the five-yearly review of the new law's policy and operation (**Recommendation 50**).

We are extremely supportive of the requirement for cultural and lived experience expertise and "experience necessary to meet the care needs of the patient" to be included in the rōpū. We would appreciate clarity on how the lived experience role will be sourced (**Recommendation 51**) – for example, will this be fulfilled by consumer advisors, or will this be a newly created role? We expect the lived experience representative would be a distinctly CPSLE role (rather than a clinician with lived experience), so that they are operating under CPSLE principles and ways of relating. We can see opportunity for the lived experience member to help give "voice" to tāngata whaiora wishes and preferences around their treatment in the rōpū whaiora and in the development of care plans, etc.

Care planning

> A more holistic assessment, maybe bringing in someone with a trauma-informed background, and also cultural, because the other part of my story is that the wairua stuff that was happening for me, that was completely missed. (Tangata whaiora, 2022)

In our view, the provisions for care planning are an improvement on the status quo. We are pleased to see that rōpū whaiora have a role in developing, reviewing and updating care plans rather than a person's care being solely determined by a single practitioner. We are very pleased to see that care plans must give effect to the will of tāngata whaiora and their care preferences, and that care plan and status reviews must have regard to the views of the support network. We have heard from tāngata whaiora and whānau that supporters' perspectives on how tāngata whaiora are doing in their recovery are often just as important as the views of clinicians providing care.

It is positive to see that the care plan must include a holistic assessment of the person, and that non-pharmaceutical options for care can be considered. We expect this will allow for better consideration of tāngata whaiora's physical wellbeing, which can be negatively affected when care is pharmaceutical driven.

Recommendation 52: The responsible practitioner must provide the records of the initial care plan (i.e., as well as records of each care plan review and status review) with the tangata whaiora as well. This appears to be provided for by a judge at times, but the obligation for tāngata whaiora to receive records of their care plans could be made clearer. It will be equally important that these are developed and presented in a clear and understandable manner (including in the person's and their support network's primary language), with adequate time and support given to comprehend the information.

Recommendation 53: Care plans should take into account people's trauma-related needs. This could be achieved by amending clause 43(4)(a)(i) to "their mental health, physical health, and social needs, including in relation to any trauma experienced by the person".

Culturally responsive care

> ...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 doctors you know... (Tangata whaiora, 2021)

Altogether, the extent to which the Bill provides for cultural responsiveness is not clear. We note that the "least restrictive application" principle states "cultural support... should be used to reduce the need for compulsion and support whanaungatanga", a person's care must reflect their "cultural needs", the holistic assessment for care planning must include "cultural considerations", and rōpū whaiora may include persons with "cultural expertise". We are interested in how these provisions will be given effect and resourced. In the section of this submission on Te Tiriti o Waitangi we have noted ways to align services more closely with tikanga and te ao Māori (such as by always having kaumātua available and growing the Māori workforce), and that implementing these practices would require increased capacity, dedicated investment and planning.

We also question if "cultural needs" or "considerations" encompasses understanding and addressing the specific needs of rainbow communities, migrants and refugees, and people with disabilities (for example).

Solitary confinement

> 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. (Tangata whaiora, 2021)

While it is great to see solitary confinement (seclusion) prohibited for people under 18 years, we are disappointed the Bill retains a provision for solitary confinement for adults. Solitary confinement has no therapeutic value and is traumatic and harmful to everyone involved.

We appreciate that the Bill allows for regulations to prohibit the use of solitary confinement in future, and the Ministry of Health's view that "the timing of, in particular, increases in workforce capacity and capability [necessary to end seclusion], are not sufficiently predictable to set a statutory deadline" (from the Regulatory Impact Statement). We agree the readiness of the system is crucial to successfully eliminating solitary confinement.

However, eliminating solitary confinement in mental health services has been government policy for over a decade. Multiple localities have achieved and sustained zero seclusion and they have been clear about how they have done it. There have been attitudinal shifts in the workforce, to the point where many staff now believe seclusion is unnecessary and zero seclusion is possible. The work of Te Pou and the Health Quality and Safety Commission has shown it is possible.

The key element that seems to be holding back the success of the Zero Seclusion Project is lack of resourcing, staffing, and adequate facilities to maintain safe and non-restrictive practice. This will not be remedied by legislation alone, but we think setting a legal time limit on solitary confinement will act as a lever to force the necessary system, service, workforce and practice change and investment in staff and facilities now, not later.

We recommend:

- Including a sunset clause for solitary confinement in the Bill, prohibiting its use after a specified time, such as within five to 10 years of the law coming into force (**Recommendation 54**).
- Expanding clause 49(1) so the obligation on "every person" to use their best endeavours to eliminate the placement of people in seclusion also applies to services. This will ensure service managers and planners are contributing the ending solitary confinement in a proactive manner (**Recommendation 55**).
- Acknowledging in clause 49 that solitary confinement serves no therapeutic purpose and is traumatic and harmful to everyone involved (**Recommendation 56**).
- Amending clause 121 to explicitly require the five-yearly review of the operation of the Act to report on solitary confinement, including frequency and length of use across facilities/regions, characteristics (including ethnicity) of those subjected to solitary confinement, and workforce capacity and capability trends and readiness for elimination (**Recommendation 57**).

We also consider that the following implementation issues will need to be addressed:

- Robust and coordinated service and facility design so staff can practice effectively and safely, including dedicated services to deliver effective responses to agitation, aggression, substance intoxication or withdrawal, and psychosis.

- Resourcing and planning must recognise and invest in kaupapa Māori approaches to reduce rates of solitary confinement and restraint, for example the use of whakawhanaungatanga on admission, mahi whakairo, mihi whakatau, sharing kai and other displays of manaakitanga. Qualitative evidence suggests these approaches are effective in reducing use of restrictive practices (Te Aka Whai Ora, 2024).
- Consider how kaupapa Māori practitioners (such as kaumātua) can be available for night shifts and weekends to ensure continuity of Māori care. "When kaumātua are present, tāngata whaiora Māori are secluded less" (Te Aka Whai Ora, 2024).

ECT and restricted treatments

> The one thing [that] is my greatest fear when I'm put under Mental Health Act, like what happened about six months ago, is the knowledge that some doctor can go "hey we're now going to do ECT" ... because they are still allowed to do that and that is my greatest fear of being under [the Act]. (Tangata whaiora, 2022)
>
> My right to choose has been taken away from me. The medication is like torture and none of the psychiatrists will acknowledge the issue with the side effects. (Tangata whaiora, 2024)

We appreciate the additional safeguards for the use of ECT in people under the age of 18 years. However, the Regulatory Impact Statement is silent on the rationale for why the restrictions on ECT for young people do not also apply to adults, for example, whether the decision is based on risks associated with brain development or whether there is a lack of clinical studies on young people to provide conclusive evidence, either way, on risk of harm.

We are aware that some jurisdictions (Victoria and Ontario) require(d) mental health review tribunal approval for the administration of ECT for adults (Cronin et al., 2017).

The proposed advocates (if well-resourced and effective) should support additional rigour around ECT decisions.

The Committee may wish to seek assurances to the following questions:

- If ECT is deemed unacceptable for use in children, why is it an acceptable treatment for adults?
- If ECT can be beneficial for adults at times, then do those same clinical indications exist for people under 18 years too?

Recommendation 58: Require the Director of Mental Health to publish an up-to-date evidence brief for ECT every five years or sooner if necessary.

The Bill should add safeguards for antipsychotics and other medications with significant side effects. The MHF has previously called for stronger checks and balances for medications with significant risk of side effects such as antipsychotic medications. The antipsychotic medication clozapine, for example, has well documented significant physical health side effects such as constipation, metabolic issues (weight gain, increased appetite), myocarditis, neutropenia and hypersalivation. Tāngata whaiora have told us they feel serious medications can be "forced" upon them with seemingly little regard to the physical side effects that they then have to live with day-to-day and in the long term, as well as the associated experiences of fear, shame, whakamā and stigma.

We understand that while patient monitoring systems do require regular blood tests (due to the risk of clozapine-induced blood problems) there are practical barriers to this such as transport to the pharmacy and necessary documentation not being available or out of date, and blood test delays can impact dispensing. Other symptom monitoring, particularly for clozapine-associated constipation (which can have serious consequences), can drop off once people transition from inpatient care to other services.

The inclusion in care plans of a holistic assessment of the person include mental, physical and social is welcomed, but we recommend the care planning provisions explicitly require the care plan to address assessment and monitoring of physical health side effects for medications that pose significant risks, including through transition from tertiary to secondary and primary care. In practice this might include, for example, a pre-emptive prescription for laxatives upon discharge from inpatient care. There are also practical system improvements that should be addressed through implementation that relate to clinical knowledge, awareness, and patient monitoring systems, such as testing flexibility, better access to phlebotomists, text reminders and faster reporting of results (Medsafe, 2024).

Recommendation 59: Amend clause 43 to explicitly require the care plan to address assessment and monitoring of physical health side effects for medications that pose significant risks, including through transition from tertiary to secondary and primary care.

Chemical restraint and/or sedation need to be strongly monitored. Currently, reporting on sedation is not collected nationally, and the accessibility of this data needs to improve. Doing so will be important to ensure that use of chemical and other forms of restraint does not increase as an unintended consequence of endeavours to eliminate solitary confinement (Health and Disability Commissioner, 2020).

Recommendation 60: The Bill's implementation should include strong monitoring arrangements for regulating chemical restraint and sedation, including by defining these terms and articulating the circumstances in which their use is permitted or restricted.

Recommendation 61: National data on the use of sedation should be included in Director's annual report.

Emergency powers

The MHF is interested in what disincentives exist, apart from reporting requirements, to discourage overuse of emergency powers.

Compulsory care assessment

> Sometimes you can make decisions one day, and then you are not so confident or not so good at making decisions for yourself another day. It's not a constant thing. You can't just assume that because you are under compulsory treatment you are unable to make decisions at any time. There should be some flexibility so that at some stage you can

> make those decisions and that you are supported to make those decisions. (Tangata whaiora, 2022)

The Bill could provide for more collaborative and impartial processes for assessment and status review.

In terms of the effect on a person's liberty and legal capacity, the second assessment period is a significant "step up" from the initial examination and first assessment period, and as such justifies greater separation of decision-making power (i.e., from the responsible practitioner alone).

Recommendation 62: Status reviews during the second assessment period, and while someone is under a mental health care order, should be conducted by the Mental Health Review Tribunal as a competent, independent and impartial legal authority.

Mental health care orders

> I've been under community treatment orders quite often and for quite long periods of time and it is very hard to get off them. Very hard. (Tangata whaiora, 2022)

There are strong grounds to discontinue community mental health care orders in most cases. New Zealand's use of community compulsory treatment is unjustifiably high by international standards and rising, despite evidence it is only effective under very limited circumstances.

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

While community treatment can offer tāngata whaiora more physical freedom than inpatient care, community treatment orders are typically active for much longer than inpatient orders, with most lasting over two years (and many, until recently,[4] applying indefinitely) (Ministry of Health, 2023). Tāngata whaiora have spoken about how hard it can be to be relinquished from a community treatment order (Te Hiringa Mahara, 2023). Their high rate of use, and typically prolonged duration, has raised the question of whether compulsory community treatment has resulted in a net reduction of coercive mental health care since its introduction in 1992, or has simply relocated the primary site of coercion from psychiatric institutions to communities (O'Brien and Kydd, 2013).

Tāngata whaiora and whānau have said that they perceive ongoing mental health support and treatment to depend on the continuation of a community treatment order and that discharge from a community treatment order means tāngata whaiora will no longer be eligible for support (Te Hiringa Mahara, 2023). It appears that community treatment orders have become a major vehicle for securing tāngata whaiora access to necessary mental health care (or where inpatient care is unavailable), while paradoxically limiting the potential for recovery by creating barriers to building trusting, collaborative relationships between tāngata whaiora and services (Te Hiringa Mahara, 2023). We hear anecdotally that community treatment orders are sometimes used to manage administrative barriers, rather than for therapeutic reasons.

Recommendation 63: Given this evidence, we recommend that consideration be given to ending community mental health orders or introduce obligations to significantly reduce their use. This should be accompanied by investment in "culturally appropriate, community-based acute and crisis services to provide genuine choice for people and whānau, alongside inpatient care" (Te Hiringa Mahara, 2023).

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

Care plan and status reviews of persons subject to mental health care orders

> ...[compulsory treatment'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. (Tangata whaiora, 2021)

We support the provisions for more regular status reviews and are hopeful this could help give effect to the principle of "least restrictive application".

Recommendation 64: Second and subsequent extensions should be reduced to six months as well, as this is more in line with a recovery approach.

Procedure for mental health care orders

Consideration should be given to reform processes for determining mental health care order applications. Tāngata whaiora have repeatedly highlighted that court hearing processes under the current Act are exclusionary, culturally unsafe and confusing, are typically conducted without adequate notice and communication, and often completely disregard family and whānau (Te Hiringa Mahara, 2023). While we appreciate the Family Court is intended to operate from an "investigative" rather than adversarial perspective, we believe the dynamics of court processes ultimately leave tāngata whaiora feeling powerless and like criminals.

We suggest establishing new procedures for decisions on mental health care orders that have multiple decision-makers (including lived experience and cultural expertise, as well as legal and clinical experts), rather than a single judge. This could be achieved through a tribunal process (using, for example, the Mental Health Review Tribunal framework) or by significantly updating the existing court approach. Doing so would provide for less adversarial and potentially more collaborative decision-making, increased flexibility including to better allow for the person to be at the centre of these events, and the power to appoint specialist members, including those with relevant expertise (such as knowledge or experience of mental distress).

Recommendation 65: Consider expanding the remit of the Mental Health Review Tribunal, or developing another tribunal-like process, to determine applications for mental health care orders.

Forensic patients and restricted patients

We support the modernising of language from "special" to "forensic". As noted previously, we recommend dividing the Bill into separate civil and forensic/restricted pathways to allow for the future merging of civil compulsory care processes into "generic" capacity legislation (**Recommendation 5**).

We encourage the Committee to be satisfied the Bill treats forensic tāngata whaiora no differently to civilian tāngata whaiora in terms of rights, quality of care, and access to complaints and advocacy, and given the inequitable number of Māori represented in forensic and restricted patient statistics (Ministry of Health, 2023), that they have equal access to care that meets their cultural needs and safety.

Reviews, appeals, and judicial inquiries

Forensic Patient Review Tribunal

We support the establishment of specialist Forensic Mental Health Tribunals, and have previously supported the Law Commission's recommendation for a move away from Ministerial decision-making to more collective/clinical decision-making for leave and change of legal status decisions, providing a clear and transparent decision-making pathway for all parties including victims.

In terms of tribunal membership, we note the Law Commission recommended "a pool of 10 to 12 tribunal members appointed, with a range of appropriate expertise. Members would require skills, knowledge or experience in one or more of the following areas: psychiatry; law (a barrister or solicitor); other senior forensic mental health; forensic consumer advice or service use; Māori issues; risk assessment and management; the reintegration of the mentally ill or intellectually impaired into society" (Law Commission, 2010).

Administration and public assistance

Mental Health Review Tribunals

The MHF supports many of the updated provisions for Mental Health Review Tribunals, including:

- The new principles, particularly those related to accessibility, the need to uphold mana and promote restorative practices, and the need that tāngata whaiora with physical, sensory and other disabilities can access and participate in the process (although we consider that at times "timeliness and efficiency" will conflict with the other principles).
- The requirement for lived experience, knowledge of tikanga and mātauranga Māori, and for tāngata whaiora under 18 years, expertise in child and adolescent development.
- The ability to co-opt members of the same ethnic identity and/or gender, persons with a disability, and/or persons with other suitable expertise, where needed. We hope this would allow for people who are non-binary or otherwise gender-diverse.

Powers and offences

> 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 [physically] unwell. (Tangata whaiora, 2021)

Police

It is now widely accepted that police are usually not best placed to provide the type of support needed during mental health (or suicide) crises, and the Government has embarked on an ambitious programme of work to transition towards a predominantly health-led response. This Bill is an opportunity to legislate for the types of responses supported by best practice, such as co-response teams or better coordinated multidisciplinary responses.

Recommendation 66: Consider requiring police to consult with health/social care professionals when deciding whether a person "meets the compulsory care criteria" and if it is "desirable in the interests of the person or of the public" to detain them and take them to hospital for assessment (cl 182). Ideally, police undertaking these tasks should be doing so as part of a multi-agency response.

While we appreciate the need to retain a legal mandate for police intervention in the Bill, there is no change to the maximum six-hour timeframe (or whenever the assessment is complete) for detainment for assessment. This would appear out of step with the Government's commitment to transitioning to a 60-minute handover for mental health assessment at emergency departments (to be phased in January to March 2025), and risks sending mixed signals to the health system and workforce about the expectations of police assistance (Australasian College for Emergency Medicine and RANZCP, 2020).

Use of force

> One of our children told me recently that witnessing me "being arrested" made her feel terrified wondering what I had done to be hand cuffed and driven away by police. (Tangata whaiora, 2024)

The MHF supports the clause 200(4) provision that "every person performing a function under this Act must use their best endeavours to minimise the use of force". We note that records on the use of force are already required under the current Act, but this data has never been included in the Director's annual reports.

Recommendation 67: National data on the use of force should be included in the Director's annual report.

Reporting

It is excellent to see the obligation on the Director-General to review the policy and operation of the Act every five years, and the establishment of the Minister's operational advisory committee. While the SACAT also has a statutory five-year operational review, we hear anecdotally of delays in making the review findings publicly available and the review has not necessarily resulted in timely operational improvements.

We support the mandated annual report on the implementation of the Act. It will be important that the same data is still reported from previous Director's reports so trends can be tracked over time.

The Committee should seek assurances as to whether:

- There are no negative implications from Directors of Area Mental Health Services no longer reporting to the Director every three months but rather as required (cl 145(3)).
- It is still necessary to provide for the official visitor role if none have been appointed since 2014.
- Consistency and quality of information on both restraint and seclusion is supported by requirements on services to keep restraint and seclusion registers being "prescribed by notice" only (cl 209). We note the current Act requires services to specifically keep a register of restraint and seclusion (s 129), and question if hospitals/services will still be required to keep these registers under the new law. Consistency and quality of information is vital for the successful elimination of these practices.

Recommendation 68: Amend clause 212 to require the Director-General to not only review the operation of the law, but to publish the review/recommendations within a reasonable timeframe, and require the Minister responsible for mental health to table the review report and respond to its recommendations (with timeframes for legislative and service improvements) in the House of Representatives within a reasonable timeframe after receiving the report.

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Appendix

Essential implementation factors for embedding supported decision-making

Law	• Legal mandate for supported decision-making.
Policy & strategy	• Supported decision-making recognised as a national priority.
Investment	• Dedicated, long-term and protected funding streams, including to fund advocates and their support structures.
Infrastructure	• Information systems that allow care directives to be stored, updated and retrieved centrally and across tertiary, secondary and primary care. • Build "pockets of excellence" and mechanisms to share best practice.
Change management leadership	• Change-oriented leadership at national and local levels. • Implementation co-designed and co-produced with tāngata whaiora and whānau Māori. • Principle Advocate role to provide stewardship for advocates.
Workforce capacity and capability	• Resourcing, support and growth of the peer support workforce. • Recruitment, training and support for advocates. • Training and professional development to support clinical staff, especially in interpersonal and communication skills, understanding of rights-based approaches to health care, to reflect upon and change unconscious bias. • Supervision and support. • Guidelines for best practice, and guidelines for all unique support decision-making roles (e.g., guidance for the nominated person and whānau to help them fulfil their roles, for example, how to handle disagreements and key concepts such as "dignity of risk".
Resource services to provide:	• Clear sign-posting of the right to access supported decision-making and the different information, tools and people available. • 24-7 availability of supported decision-making tools and people. • Access to full and non-biased information about rights, legislation, and processes (including information about decision-making supports that are available). Information should be simple, clear,

	available in different formats, and adequate time and support should be given to comprehend the information. • Decision-making practices that enable tikanga Māori and be culturally relevant and safe for Māori, such as through valuing wairuatanga and facilitating collective decision-making. • Flexibility – o The time and setting of decisions should be physically, spiritually and emotionally safe, which might include the person's home and/or a time outside normal working hours. o Compulsory care directives developed in a range of accessible and comfortable settings, such as in a person's home or community. o Compulsory care directives provided in a range of format options, such as audio or video recording as well as in writing. o Where a decision is not urgent, there should be no deadlines or time pressure to make the decision. • Genuine choice and options where possible (e.g., in respect of decisions about living arrangements or medical treatments). • Regular opportunities to review and/or change decisions and reflect on or debrief the way they have been applied.
Monitor & review	• Local and national reporting of supported decision-making infrastructure, workforce, processes and practices, and outcomes for tāngata whaiora. • Assessment of implementation effectiveness and recommendations for operational improvements at the five-year Act review.