

Submission to the Ministry of Health on updated Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992

17 January 2020

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

Introduction

Thank you for the opportunity to provide feedback on the Ministry of Health's update of *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* ('the guidelines'). This submission is led by the Mental Health Foundation and supported by the Like Minds Like Mine public awareness programme to increase social inclusion and end discrimination towards people with experience of mental distress.

We believe the Ministry's decision to extend and widen consultation on the guidelines is a good one. The Mental Health Foundation has been able to gather feedback from people with lived experience of mental distress to help develop this submission. Our consultation process has received positive feedback, and will go a long way to continue the good relationships and trust the Ministry has developed as it implements the work programme in response to *He Ara Oranga*.

The Mental Health Foundation (MHF) fully supports the recommendation in *He Ara Oranga* to repeal and replace the *Mental Health (Compulsory Assessment and Treatment) Act 1992* ('the Act') and we look forward to working with the Ministry as it prepares for this over the next few years.

This guideline update constitutes a real opportunity to change the way the Act is used in practise from 2020, towards a more human rights-based approach that removes discrimination on the basis of an actual or perceived disability, and where coercion is used as a last option and temporarily. It is also an opportunity for the Ministry to examine the extent of racism and prejudice in the application of the Act and its potential to significantly harm hauora Māori.

MHF position on mental health law reform

New Zealand's mental health services need to move away from over-use of compulsory treatment and outdated, non-therapeutic practices such as seclusion and restraint, which are used more with Māori than other groups. The MHF's position to date is that mental health legislation in Aotearoa New Zealand, and related policy, service provision and clinical practice, must:

- demonstrate adherence to the principles and intentions of Te Tiriti O Waitangi
- eliminate inequities for Māori
- reduce inequity for other priority groups, such as Pasifika and rainbow people
- be co-designed by tangata whenua and tangata whai ora (people with lived experience of mental distress)
- grow and value the role of peer support workers in the system (peer support is defined as people with lived experience of mental distress who have previously received support under mental health services)
- ensure the protection of human rights and wellbeing
- eliminate discrimination and prejudice against those experiencing mental distress
- avoid the use of compulsory treatment wherever possible through promoting supported decision-making and good consultation practises with whānau
- eradicate the use of seclusion and minimise the use of restraint.

Commitment to comprehensive review of guidelines and supporting materials

We appreciate this update seeks to address immediate concerns with the guidelines, and it is not pragmatic to address many of the systemic problems with the document in this current update. **Therefore, we ask the Ministry to commit to a timeframe for a comprehensive review of the guidelines, preferably alongside the 2020 legislative review.**

Such a review should consider the following:

- I. **Reflect te ao Māori:** Work in collaboration, consultation and agreement with Māori (as obligated under Te Tiriti O Waitangi) in reviewing the guidelines to ensure the language truly reflects a te ao Māori view rather than a Pākehā interpretation of Māori concepts.
- II. **Structure and usability:** The document is repetitive and at times contradictory. Guidance on key policy issues such as supported decision-making arises in multiple places but is not entirely comprehensive in any one place, which places the reader at risk of missing key information. The document would benefit from being significantly re-organised.

- III. **Commitment to regular review:** We recommend an obligation for regular review is built into the guidelines to ensure they are up-to-date and fit for purpose.
- IV. **Implementation:** For the new guidelines to instigate real difference in the clinical practice of individuals, particularly in the way Pākehā clinicians work with Māori, they will have to be delivered and implemented in a way that is accessible and meaningful. We are concerned clinicians will not read a lengthy document or only read it in a piecemeal way. We strongly recommend the Ministry, working alongside the Royal Australian and New Zealand College of Psychiatrists, considers ways to bring the guidelines to life for clinicians. This could include case studies or videos from the perspective of tangata whai ora, possibly as part of the College's e-learning platform for continuing professional development.
- V. **National oversight:** There is scope for the new Mental Health and Wellbeing Commission to have oversight over how the guidelines are implemented, with particular regard for how culturally safe care is administered, and whether the guidelines are fit for purpose. This would appear to fit within the powers of the Commission as outlined in the current Bill to "publicly report on any matters concerning the mental health and wellbeing of people in New Zealand; and make recommendations to any person (including any Minister) on any matters concerning mental health and wellbeing."
- VI. **Accountability:** we will be seeking further information about how DHBs are working with Māori to ensure systems, procedures and audits are in place to monitor and hold DHBs accountable for administering the Act in culturally safe ways. This must be supported by Te Tiriti o Waitangi training; cultural induction for new staff; using processes, tools and tikanga Māori to reduce seclusion and restraint; funding for cultural specialists as part of multi-disciplinary teams; Māori peer support workers; and the availability and use of Māori mental health teams across DHBs. DHBs need standardisation to ensure a consistent standard of practice throughout the country so that all DHBs are functioning in an equally culturally-safe manner.
- VII. **New supplementary advice for diverse communities:** While the guidelines attempt, in good faith, to highlight important issues for Māori, Pasifika, and rainbow people, they are not comprehensive. We appreciate it might not be possible to include this sort of in-depth information given the breadth of advice covered by the guidelines, in which case we recommend the Ministry consider funding community organisations to develop more detailed guidelines for health practitioners about how to work with diverse communities when applying, or seeking to apply, the Act. This would complement the current guidelines with detailed and nuanced advice that is currently lacking.

VIII. **More support and guidance for family/whānau:** *He Ara Oranga* recommended the Ministry, working with other government agencies, lead a review of the support provided to families/whānau of people with mental health and addiction needs and to fill any existing gaps. We support this recommendation, the need for which is evidenced by the Mental Health Commissioner's recent finding of low levels of service contacts to support family/whānau of consumers.^[1] Family/whānau have told us they need a person who has experience of the Act to talk to them about what is going to happen, the rights of tangata whai ora and their family/whānau, what to expect from nurses and doctors etc. There are strong recommendations that this role be undertaken by someone with lived experience of mental distress who has previously received support under mental health services (peer support). Some see the peer support worker to be similar to the role of a kaumatua/kuia who guide whānau about tikanga at tangi or a funeral director who makes funeral arrangements with families; someone who can step in when whānau/families are in a state of bewilderment and are unfamiliar with system processes. They also want plain language (in English, te reo Māori, sign language or whatever language is appropriate to them and their family/whānau) and easy-to-read information about each process under the Act, and a glossary of terms clearly explained.

Feedback on guidelines

Overall, we are pleased the revised guidelines acknowledge the importance of addressing inequity for Māori, of Te Tiriti o Waitangi, of rights-based and recovery approaches, promoting supportive decision-making, diverse gender and sexual identities and the effects of intersectionality, strengthening the obligation to respect cultural and identity diversity, and working alongside family/whānau at all stages. We like the additional acknowledgement that intervention under the Act often raises concerns for those subjected to it and their whānau about rights and privacy – this goes some way to acknowledging the trauma and distress often associated with being subjected to the Act.

Our feedback makes several suggestions to clarify and strengthen the guidelines, which is informed by wānanga with Māori with lived experience of mental distress who have previously received support from mental health services; whānau; and clinicians with experience of the Act. Our key points are as follows:

- I. Discussion of Te Tiriti o Waitangi should be the first, and a stand-alone, section of the guidelines, with additional examples added about how the five principles might apply in practise.
- II. The relationship between intergenerational trauma, racism and mental illness should be highlighted in the guidelines; and requirements for providing

^[1] Health and Disability Commissioner. 2019. *New Zealand's mental health and addiction services: Monitoring indicator update 2017 & 2017/18*. Wellington: Health and Disability Commissioner.

- 'culturally safe care' as defined by the Medical Council of New Zealand should be strengthened.
- III. The guidelines should require follow-up on unexplained and unjustified decisions not to consult family/whānau; and they should encourage clinicians to assign family/whānau a support worker or refer them to appropriate services such as Supporting Families in Mental Illness.
 - IV. Rainbow representatives (including Takatāpui) should be involved in the guidelines' development to ensure the guidelines are as accurate and helpful as possible for these communities, including correcting the definition and explanation of terms where necessary.
 - V. The guidelines should make it clear that supported decision-making must be the first step in interactions with tangata whai ora, and once the Act has been engaged, supported decision-making must be a routine part of all decision-making processes.
 - VI. The guidelines should state that the supported decision-making process should also involve a peer support worker.
 - VII. The guidelines should introduce a new reporting requirement pertaining to the number of patients on indefinite treatment orders, and additional safeguards added to create a higher threshold for the justification of the extension of compulsory treatment orders.
 - VIII. The guidelines should include clearer advice that discussions about treatment options should include talk therapy as well as alternative therapies such as rongoa Māori, karakia, and whakawaatea.
 - IX. The guidelines should include more advice or examples about the circumstances in which ECT could be administered 'in the interests of the patient' to clarify when it should be used or not, including cultural considerations about the head as tapu.
 - X. The guidelines should include a new target date for the elimination of seclusion; and the reporting template should be amended to facilitate better data collection to understand factors related to seclusion rates and to highlight the importance of culturally safe care in reducing the number of Māori subject to seclusion practices.

We also make recommendations that fall outside the scope of this update but are important and relevant to wider system changes. These pertain to reviewing options for providing free or subsidised medication and other financial supports for people who have recently exited a compulsory treatment order and to reviewing procedures in *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* to assess what more could be done to avoid long-term seclusion.

Te Tiriti o Waitangi (1.1.)

We believe discussion of Te Tiriti o Waitangi should be a stand-alone section (not a subsection) and not conflated within a wider discussion on human rights. Furthermore, this should be positioned as the first section in the guidelines, affording it the importance it deserves under Crown obligations to uphold its Treaty obligations. We like the explanations about how these five principles apply when clinicians seek to consult with Māori whānau (section 5) but feel more examples about how the

principles apply practically in other areas of the guideline would be helpful. For example, *tino rangatiratanga* may also mean seeking ways to care for a person through tikanga Māori as the first step; *equity* can mean ensuring Māori practitioners, Māori specialists and Māori peer support workers are involved in clinical matters prior to the administration of the Act; and *active protection* can refer to applying rituals of engagement when making sure the person's spiritual wellbeing is protected.

Cultural responsiveness

Advice relating to cultural identity and cultural responsiveness needs to separately address the unique needs for a) Māori b) Pasifika and c) other ethnicities. Care should be taken to separate out the advice as it relates to each of these groups rather than condensing it together.

Respect for cultural and personal rights (section 4)

The guidelines note high rates of serious mental illness, co-existing conditions and complex and late presentations as one of the many explanations for why Māori are significantly over-represented in populations treated under the Act. Clinicians also need to be aware of social and economic determinants of mental health and the relationship between intergenerational trauma, racism and mental illness, and we recommend these be explicitly identified as causes of the high rate of Māori treated under the Act.

We are pleased the guidelines acknowledge the role of both individual practitioners and services in being culturally responsive, and that the guidelines go beyond a cultural competence requirement for clinicians. However, it is unclear why the term 'culturally responsive care' is being used over 'culturally safe care', which is outlined in the recently updated New Zealand Medical Council standard.¹ It would seem practical for the guidelines to align to the definition and standards of culturally safe care as much as possible, which is defined as:

"The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.

The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.

The awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities [including whānau, hapū and iwi]²."

¹ Medical Council of New Zealand. Statement on cultural safety.

<https://www.mcnz.org.nz/assets/standards/b71d139dca/Statement-on-cultural-safety.pdf>

² Bracketed text shows preferred wording by the MHF and not the final text of the standard itself.

Furthermore, we recommend the guidelines:

- I. be strengthened to ensure services have a duty to make cultural assessment routine rather than to have 'arrangements in place'
- II. make clear clinicians must be culturally safe not only in providing treatment but throughout the whole process, including in providing information, assessment and review, and seeking consent
- III. strengthen the role of culturally-appropriate peer support workers
- IV. provide practical examples of how clinicians might apply Māori and Pacific models of care in their practice, for example, by offering a holistic approach to treatment or discussion about spiritual concerns and beliefs.

Consultation with family/whānau (section 5)

In 2017, a national average of 60 percent of families/whānau were consulted about assessment/treatment events. The most common reason DHBs gave for not arranging family/whānau consultation was that it was not reasonably practicable (60%). This was followed by 'don't know' (28%), 'not in the best interests of the person' (6%), 'for another reason' (6%),³ suggesting considerable scope to improve the rate of family/whānau consultation throughout the stages of the Act, particularly given no justifiable reason was provided in a large proportion of cases.

We are pleased the guidelines go further than the basic requirements of the Act by reinforcing consultation as an ongoing process undertaken at all phases and stages of the assessment and treatment process, and it must be responsive to patients' needs and cultural values. The additional advice to document the rationale behind clinicians' decisions not to consult patients' family/whānau will help to better understand these types of decisions and why they vary significantly across DHBs. The clearer the advice about what does and does not constitute 'reasonably practical' could also help to minimise the number of cases where family/whānau are not consulted under this criterion.

We also ask the Ministry to consider the following amendments to the guidelines.

- i. Require the relevant Director of Area Mental Health Services to follow up on decisions not to consult family/whānau when such decisions do not meet legal criteria (currently documented as 'don't know' or 'for another reason'); and require the Director of Mental Health to consider what action could be taken in order to deter unlawful decisions.
- ii. In addition to suggesting clinicians inform family/whānau that they may contact a district inspector, the guidelines should also encourage services and clinicians to assign a culturally appropriate peer support worker to

³ Ministry of Health. 2019. *Office of the Director of Mental Health and Addiction Services: Annual Report 2017*. Wellington: Ministry of Health.

family/whānau, and to also refer them to a service such as Supporting Families in Mental Illness to help them to navigate the process and be aware of and assert their rights about family/whānau consultation.

The guidelines use a mix of phrasing to describe clinicians' obligations ahead of consulting with family/whānau, such as "...desirable to discuss the consultation process with the patient...", "...*should* obtain a patient's consent to consult family/whānau whenever possible..." and "...they *must* first consult the patient...". The guidelines should be clear about what requirements are imposed under the Act (i.e., the practitioner must consult the proposed patient or patient) and what additional obligations, if any, the guidelines place on clinicians (i.e., to seek patient consent as a matter of good practice).

Rainbow communities (4.1.)

As stated above we are pleased the guidelines acknowledge and discuss issues of relevance to rainbow communities, such as intersectionality and minority stress, which we feel has been accurately described by the guidelines. However, several aspects of this advice need to be further developed alongside rainbow representatives to ensure the guidelines are as accurate and helpful as possible. For example:

- I. We recommend the term 'rainbow communities' (plural) be consistently used as it reflects a collection of diverse communities spanning sexual orientations, gender identities, sex characteristics, cultural paradigms, geographic spaces, generations, and other diversities.
- II. The definition (or implied definition) of rainbow communities must explicitly include diversity of sex characteristics (people born with intersex variations) as well as gender identities and sexual orientations.
- III. The list of 'other words people might use' are not reflective of simply 'gender identity' as suggested by the guidelines. Many of these are traditional and culturally-based identity terms that are not directly equivalent to Western views of sexuality and gender identity and as such need to be couched in ways that acknowledge a different world view.
- IV. It would be useful to discuss terms such as Takatāpui and fa'afafine as part of the discussion on intersectionality. For example, Takatāpui may experience minority stress related to being Māori, as well as related to their sexuality, sex or gender.
- V. A person's experiences of dissonance between their gender identity and their sex assigned at birth, or their non-heteronormative sexual orientation can lead to experiences of mental distress because of the social, cultural or familial pressures to conform to heteronormative and cis-normative ideals. While well-intentioned, this section needs to be carefully worded so as not to inadvertently imply that a person's experience of diverse gender or sexual orientation is the reason for mental distress as this could be exploited by some practitioners as a justification for conversion therapy, which is currently a legal practice in Aotearoa New Zealand.

To assist in addressing these points, and more, we recommend "[Rainbow communities, mental health and addictions - a submission to the Government Inquiry into Mental Health and Addiction Oranga Tāngata, Oranga Whānau](#)", available on the MHF website; this informative submission represents a collective view of diverse organisations, groups, researchers and individuals who work to support the wellbeing and mental health of rainbow people and communities.

Supported decision-making (1.3)

The MHF supports strong incentives for supported decisions, both during decision-making under the Act but also importantly when decisions need to be made about a person's psychiatric care and treatment and the Act has not been engaged. We suggest this section of the guidelines be strengthened in the following ways:

Firstly, supported decision-making should be done with a peer support worker present, and it must be the first step in interactions with tangata whai ora. The simple act of empowering tangata whai ora to be supported to make their own decisions, can actually assist in reducing the use of coercion in the first place.⁴ It is at this early stage, before the Act is engaged, that clinicians should take part in a genuine partnership with tangata whai ora by discussing a full range of care and treatment options available as an alternative to coercive treatment. We recommend the guidelines emphasise this important role for supported decision-making and in doing so reflect on how the principle of *tinō rangatiratanga* could be applied, for example, in offering talk therapy, rongoa Māori, karakia, and whakawaatea, and respite care in kaupapa Māori mental health and addiction services and mainstream services.

Secondly, once the Act has been engaged, the advice should make it clear that supported decision-making and peer support are *routine* parts of all decision-making processes under the Act and clarify that the only situations where it is justifiable not to undertake supported decision-making is where a) an urgent decision needs to be made, b) the clinician is satisfied the person does not have the capacity to consent for this particular decision after undertaking a capacity assessment, or c) the patient is experiencing significant distress at the time the decision needs to be made in which case supported decision-making should be revisited when the person is stable.

Thirdly, as currently drafted, most of the advice about supported decision-making is in section 1, but the advice in section 10 about capacity, fluctuating capacity and dignity of risk, and in subsection 11.4 on providing patients with information they can understand and in an appropriate environment and time, is also relevant. There is a risk the reader may miss important information if they only read the subsection labelled 'supported decision-making'. We think it should be a priority of this update (rather than waiting for a full review) to provide a comprehensive summary of supported decision-making in one section and link to or remind the reader about key points where appropriate.

⁴ Brophy et al. 2019. Community Treatment Orders and supported decision making. *Frontiers in Psychiatry*, 10, 414.

We are pleased the guidelines recognise that recovery planning should be undertaken by tangata whai ora themselves, with support from their clinician and family/whānau. We would add this should also be undertaken with the wider multidisciplinary team where possible, including a peer support worker.

The Ministry of Social Development is developing a practical resource for supported decision-making, which is an action under the Disability Action Plan under the priority to 'Ensure disabled people can exercise their legal capacity, including through recognition of supported decision making'. It would be useful to link the reader to this resource when it is publicly available in 2020 and align the guidelines, where possible, to its definitions and advice.

Compulsory treatment orders (section 7)

The MHF endorses the abolition of indefinite compulsory treatment orders in place of a requirement for positive renewal by the court at period intervals and mandatory judicial or tribunal review whenever a compulsory treatment order is renewed.⁵ This could also include judicial or tribunal monitoring of recovery plans and cultural assessments. However, in lieu of legislative change we make the following recommendations.

First, we recommend the guidelines introduce a new reporting requirement to the Director of Area Mental Health Services on 1 July 2020 pertaining to the number of patients on indefinite treatment orders, where a copy of each clinical review that determines a patient is not fit to be released from indefinite compulsory status is provided. Currently, no clear records exist for long-term use of community treatment orders.⁶ This data could be used to capture the annual number and average length of long-term treatment orders, their distribution across DHBs and longitudinal trends.

Secondly, we recommend the Ministry consider additional safeguards to create a higher threshold for the justification of the extension of compulsory treatment orders. This could include, for example, requiring clinicians alongside a peer support worker to consult with the patient and their family/whānau when undertaking a clinical review of the patient at every six-month interval rather than simply 'examining the patient' and consult other health professionals in their care as required under the Act.

Lastly, through our lived experienced consultation, we have heard the provision of free medication under the Act provides an incentive for some tangata whai ora to stay under treatment orders. Although outside the scope of this update, we recommend the Ministry review possible options for allowing the continuation of free or subsidised medication for people who have recently exited a compulsory treatment order, as well as during mental health service transitions. There may also be merit in

⁵ Recommended in Bell, S., & Brookbanks, W. (2017). *Mental health law in New Zealand (3rd ed.)*. New Zealand: Thomas Reuters New Zealand Ltd.

⁶ Mental health and human rights factsheet (2018).
https://www.hrc.co.nz/files/1815/4102/3498/Mental_health.pdf

assessing whether other financial supports gained while under treatment orders, such as disability allowances have an unintended incentivising role due to fears held by some tangata whai ora that they will not survive financially outside of treatment. If this is so, we should be asking how we could better support the financial stability of tangata whai ora after treatment. Such support could bring a greater sense of confidence to exit treatment orders and assist in continuing recovery in the community.

Compulsory treatment (section 10)

A strong theme in the Ministry's previous consultation work and our own insight gathering from tangata whai ora is that a limited range of intervention options are offered. For many tangata whai ora, treatment under the Act predominantly takes the form of medication, often with severe side-effects. Tangata whai ora have talked about their fear of the long-term risks of taking medication as a cycle whereby more medication is needed to counter side-effects and they feel "brainwashed into taking medication forever." To address both Ministry findings and our own, the advice given to tangata whai ora and their whānau/family when professionals are discussing available medication options should also include explicitly identifying a range of talk therapies, as well as alternative therapies such as rongoa Māori, karakia, and whakawaatea. A peer support worker should also be part of the discussions. Section 11.4 of the guidelines acknowledges that interventions other than medication need to be discussed but this needs to be clearly stated in section 10, or the sections should be combined in some way.

Electroconvulsive treatment (10.3)

The guidelines should make it clear that when a clinician is seeking consent for electroconvulsive treatment (ECT) they should not only tell tangata whai ora about 'expected benefits and side-effects [of ECT]' but also other available treatment options to ensure they are fully aware of alternative treatments and help to minimise possible coercion. Peer support workers should also be present during these discussions.

Providing further advice or examples about the circumstances in which ECT could be administered 'in the interests of the patient' might be helpful to clarify when ECT should be used or not. This might include relevant information that clinicians should consider in making this decision, along the lines of the advice on the 'best interests' test in section 5. In terms of cultural considerations, the guidelines should note that ECT may breach tikanga because the head may be considered tapu and this must be taken into account with whānau Māori. The advice should make clear that clinicians alongside a peer support worker must record their reasoning behind any decision to administer ECT in the interests of the patient, and when/if the patient lacked capacity to consent or consent was refused.

Rights of patients and proposed patients (section 11)

Right to company and seclusion (11.8)

We recommend the Ministry include a new target date for the elimination of seclusion in the guidelines. Simply noting the eight-year-old goal, set in 2012, to reduce and eventually eliminate seclusion does not send a strong signal that the Ministry is committed to delivering the zero-seclusion goal. Clinicians should be strongly encouraged to be aware of this goal, and engage with DHBs and inpatient services as they work towards it.

We also recommend the Ministry consider the following.

- I. Facilitate better data collection to understand factors related to seclusion rates in and across DHBs.⁷ For example, the seclusion reporting template in *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* could be amended to provide a checklist of factors that may have influenced the use of seclusion for each case, such as de-escalation, tikanga Māori approaches, peer support workers, and use of alcohol and other drug detox facilities etc. Currently there is a blank space to give a detailed account of the event.
- II. Acknowledge the roles that trauma-informed care, recovery approaches, human rights, and supported decision-making (section 1) – and culturally safe practice, routine cultural assessment (section 4 with our amendment) – play in reducing the use of seclusion and restrictive practices. Specifically, the guidelines could highlight the importance of culturally safe care in helping to reduce the significant over-representation of Māori in seclusion practices, with international evidence suggesting that ethnic or racial stereotyping of psychiatric inpatients by healthcare workers may influence management with regard to the use of coercive measures such as seclusion.⁸

While outside of scope of this guideline update, we remain concerned that the legislation and procedures outlined in *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992* place no limitation on the long-term use of seclusion and restraints, although safeguards are in place. While we await legislative reform, we recommend the Ministry review current procedures to assess what more could be done to avoid long-term seclusion.

Summary

The Mental Health Foundation and the Like Minds Like Mine programme offer ongoing support for the development of the Guidelines, which, if done well, will remove

⁷Using data for continuous quality improvement was signalled in Te Pou o te Whakaaro Nui. (2008). *Reducing and eliminating seclusion in mental health inpatient services: An evidence review for the Health Quality & Safety Commission New Zealand*. Auckland, New Zealand: Te Pou o te Whakaaro Nui.

⁸ Spector R. (2001). Is there racial bias in clinicians' perceptions of the dangerousness of psychiatric patients? A review of the literature. *Journal of Mental Health*, 10:5–15.

discrimination, address racism, and greatly improve the application of care and support for tangata whai ora and their families/whānau. It is hoped also that the feedback we have provided for the Guidelines will contribute towards setting in motion the final changes we need to see in the rewriting of New Zealand's outdated Mental Health Act.

A handwritten signature in black ink, appearing to read 'S. Robertson', with a long horizontal flourish extending to the right.

Shaun Robertson

Chief Executive Officer

About the Mental Health Foundation

The MHF's vision is for a society where all people flourish. We take a holistic approach to mental health and wellbeing, promoting what we know makes and keeps people mentally well and flourishing, including the reduction of stigma and discrimination (particularly on the basis of mental-health status).

The MHF is committed to ensuring that Te Tiriti o Waitangi and its Articles are honoured, enacted, upheld and incorporated into our work, including through our Māori Development Strategy. We are proud that Sir Mason Durie is a Foundation patron.

The MHF takes a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities, create support and social inclusion for people experiencing distress, and develop positive mental health and wellbeing. Our positive mental health programmes include Farmstrong (for farmers and growers), All Right? (supporting psychosocial recovery in Canterbury, Kaikōura and Hurunui), Pink Shirt Day (challenging bullying by developing positive school, workplace and community environments), Open Minds (encouraging workplaces to start conversations about mental health) and Tāne Ora (working with tāne Māori and their whānau to build wellbeing skills). Our campaigns reach tens of thousands of New Zealanders each week with information to support their wellbeing and help guide them through distress and recovery.

We value the expertise of tangata whai ora/ people with lived experience of mental distress and incorporate these perspectives into all the work we do. Established in 1977, the MHF is a charitable trust, and our work is funded through donations, grants and contract income, including from government.