



Te Kāwanatanga o Aotearoa
New Zealand Government



Transforming Mental Health Law in Aotearoa New Zealand

**Overview
document**

This is an overview of the full discussion document for transforming mental health law in Aotearoa New Zealand. The full discussion document can be found on the Ministry of Health [website](#).

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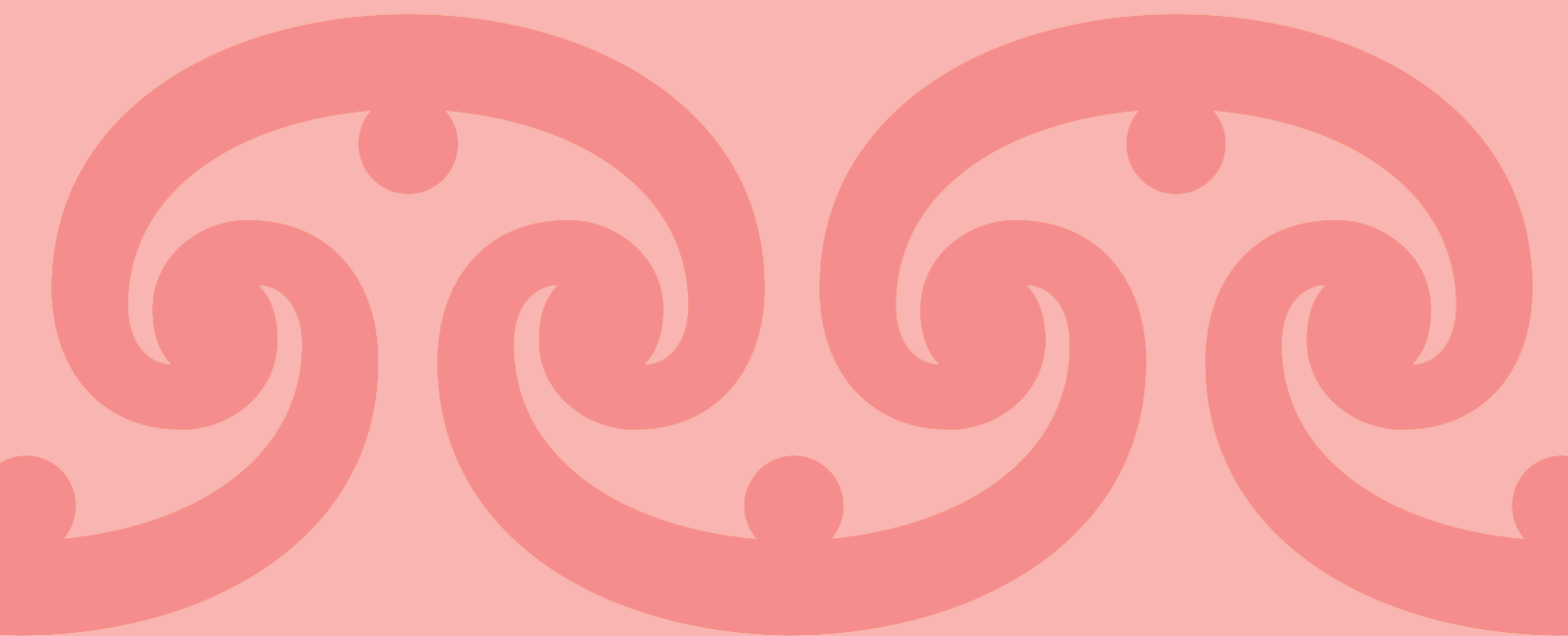
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Why we would like to hear from you

We are transforming Aotearoa New Zealand's approach to mental health and addiction, so that people can get the support they need, when and where they need it. Ensuring we have fit for purpose legislation is one part of this transformation.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 has not kept pace with the international shift towards a recovery and wellbeing approach to care and has never been comprehensively reviewed.

Most people in Aotearoa New Zealand who access specialist mental health and addiction services will not be placed under the current Mental Health Act – in 2019, less than six percent of people using specialist mental health and addiction services were placed under the Act.

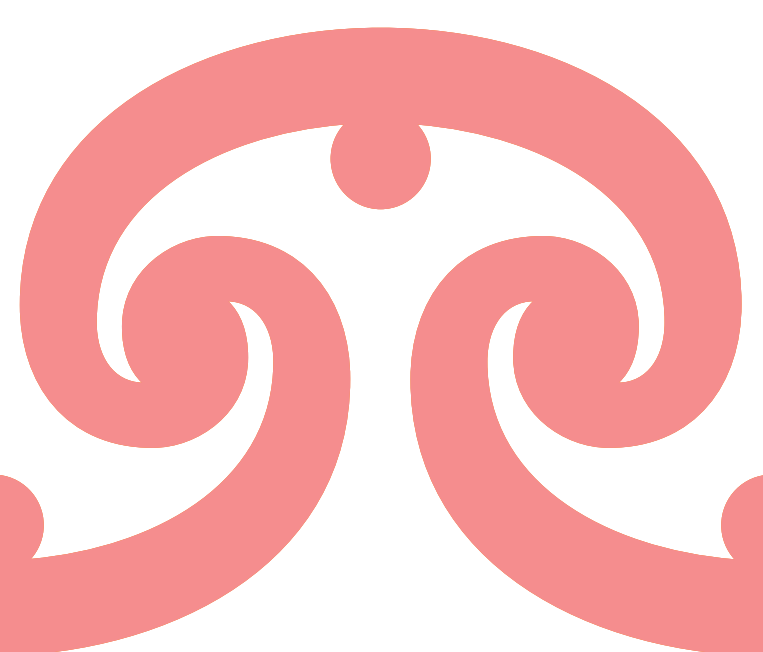
Although the current Mental Health Act is only used for a small proportion of people each year, it has a big impact on the lives of those who do experience it, and their family and whānau.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction recommended repealing and replacing the Mental Health Act with legislation that “reflects a human rights-based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment”.

The Ministry of Health has made improvements to the current legislation including new guidelines to improve how the current Mental Health Act is applied and introducing the Mental Health (Compulsory Assessment and Treatment) Amendment Bill. One of the critical features in the Bill is eliminating indefinite treatment orders.

We have heard why change is needed, and the next step is to get clear direction for what new mental health legislation in Aotearoa New Zealand should look like.

We are now opening public consultation – your feedback on the topics in this document will help the Government develop new mental health legislation.



Make a submission

You are invited to give feedback on the whole discussion document or just the parts you are most interested in or impacted by. You might have other views and concerns that we have not captured, and we encourage you to tell us about these.

Consultation is open until **28 January 2022** and you can get help to prepare and submit your submission.

You can provide feedback by:

- making an online submission at consult.health.govt.nz
- answering the questions in the consultation document and emailing your responses to mhactreview@health.govt.nz
- answering the questions in the consultation document and sending a hard copy to:
Ministry of Health, PO Box 5013, Wellington 6140

Navigating the discussion document

The discussion document has been divided into nine parts. This overview offers a summary of each part, but there's a lot more information available in the full discussion document.

Parts One and Two give background information about the current Mental Health Act, reasons for repealing and replacing it, and how new legislation will contribute to the transformation of mental health and addiction services.

Parts Three to Nine each focus on specific topics for discussion. The topics covered are:

- Embedding Te Tiriti o Waitangi and addressing Māori cultural needs (Part 3)
- Defining the purpose of mental health legislation, including using a human rights approach and whether compulsory mental health treatment should ever be allowed (Part 4)
- Defining why, when and how compulsory mental health treatment, if permitted, might be appropriate (Part 5)
- Making sure people are able to use appropriate tools to support them to make decisions about their care and treatment (Part 6)
- Considering the use or prohibition of seclusion, restraint, or other restrictive practices (Part 7)
- Addressing the needs of specific populations: people from different cultures, family and whānau, children and youth, disabled people, and people from the justice system (Part 8)
- Ensuring people's rights are protected and monitored (Part 9).

Three Appendices at the end of the discussion document give extra information about the current Mental Health Act, international examples, and Aotearoa New Zealand's key human rights laws and international agreements. There is also a glossary defining some of the words used in the document.

Seeking support when making your submission

It can be tough making a submission about something that is important to you, or that might remind you of difficult past experiences. You can use a support person/network to help you with making a submission, or for support if you find the process difficult.

If you need additional support, you can also **call or text 1737** to connect with a trained counsellor or peer support worker. The 1737 service is completely free and available any time, 24 hours a day.

Official Information Act

All submissions (responses) that are made about this document will be considered official information under the Official Information Act 1982. This means that copies of your submission may be requested under the Official Information Act and may need to be released.

If there is information in your submission you would like to be withheld (not released to the public), please make it clear in your submission what this content is and why you think it should not be released.

Decisions to release information or not will be made using the criteria in the Act. Personal health information will not be released.

What will happen next

Your feedback and responses to the questions in this document are an important part of the process to develop new mental health legislation.

After the closing date for submissions, an independent external organisation will review and analyse all the information we receive. Then we will develop recommendations for new legislation and give this to the Government to consider.

Once the Government has agreed to the policy for new legislation, a Bill will be created and introduced to the House. This process can take some time, especially for complex legislation like this.

— **For more information on all of the steps involved, please see the webpage *How a bill becomes law* on the [New Zealand Parliament website](#).**

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PART 1

Where we are now

The current Mental Health Act sets out when, why and how the government can intervene in a person's life to give them mental health treatment against their will.



How we got here

From the 1960s, mental health treatment in Aotearoa New Zealand began to shift away from psychiatric hospitals towards community-based care, with a greater focus on a person's role in their own recovery.

The current Mental Health Act became law in 1992. It was seen as a step forward because it focused on providing care in the least restrictive way and encouraged community-based care over hospital care whenever possible. Importantly, the Act included better protection of patients' rights.

In 1999, the current Mental Health Act was updated to say that mental health services needed to consult with families and whānau as much as possible.

Who can be placed under the current Mental Health Act

Only a small proportion of people in Aotearoa New Zealand who access specialist mental health and addiction services will be placed under the current Mental Health Act. The Act currently applies to anyone, including children.

Before someone can be put under compulsory assessment or treatment, the person must be considered to have 'an abnormal state of mind' and there must be signs that the person might pose a serious danger of harm to themselves or others, or be unable to take care of themselves.

The process for the current Mental Health Act

1. An initial assessment is made by a mental health practitioner to see whether a person meets the requirements of the Mental Health Act.
2. If they believe the person should be placed under the Act, the mental health practitioner issues a certificate of their initial assessment confirming that more assessment is needed.

Compulsory assessment

3. This next assessment is called compulsory assessment. Compulsory assessment can take place in either a community or hospital setting (inpatient unit).
4. There are two periods of compulsory assessment. The first period of assessment is for up to five days. The second period can last up to 14 days.
5. During the assessment period, a person must receive the treatment prescribed by the health professional in charge of their care and treatment (the responsible clinician).
6. The responsible clinician may release the person from the assessment at any time, and the person (or someone acting on their behalf) can request a review into whether they still need to be under the Act. A judge makes this decision based on information from clinicians.
7. After the first two assessment periods, if the responsible clinician believes the person still meets the criteria for compulsory treatment, they can apply to the Family or District Court to put the person under a compulsory treatment order.

Compulsory treatment

8. There are two types of compulsory treatment orders: an order for treatment in the community or an order for treatment in an inpatient unit.
9. During the first month of compulsory treatment, a person must receive the treatment that their responsible clinician prescribes, even if they don't want treatment.
10. After that month, the person must consent (agree) to treatment in writing. However, the current Mental Health Act still says treatment can be given without consent if another psychiatrist considers the treatment to be 'in the interests' of the patient.
11. While under a compulsory treatment order, the person must be clinically reviewed by their responsible clinician three months after the beginning of the order and then at least once every six months.

What compulsory treatment means for a person

Compulsory treatment limits the right of people to refuse medical treatment, as outlined in the New Zealand Bill of Rights Act 1990. This means that – for the first month – a person must accept medication or other mental health treatment prescribed by their responsible clinician, whether they agree to the treatment or not.

A compulsory treatment order under the current Mental Health Act only relates to mental health treatment; it does not limit a person's right to refuse other health treatment.

Limits or restrictions for someone under a compulsory treatment order

- A compulsory treatment order limits a person's right to refuse medical treatment.
- A person under a compulsory treatment order in an inpatient unit has to remain in hospital, which is a form of detention as it limits freedom of movement.
- The current Act allows seclusion, which is when a person is placed alone in a locked room.
- A person under a community compulsory treatment order might have to allow community mental health team workers into their home, or attend treatment appointments at specific places. They may also need to get approval from their treatment team before they can travel.
- There is a stigma associated with being under a compulsory treatment order which may lead to discrimination, for example affecting housing, employment, or social opportunities.

Why the current Mental Health Act is being replaced

He Ara Oranga states that the current Mental Health Act is out of date and doesn't meet Aotearoa New Zealand's international human rights obligations.

Additionally, the Act does not appear to always support improved mental health outcomes or the wellbeing of individuals overall and may be contributing to significant inequities.

The use of compulsory treatment orders varies by district health board (DHB) and compulsory treatment orders are used more often on Māori and Pacific peoples compared to the population overall. Almost half of all people on a compulsory treatment order are on an indefinite treatment order (a compulsory treatment order with no end date).

Evidence of inequities under the Act

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Health inequities are caused by social, cultural and/or economic factors, and can't be fixed by the health system alone.

Equity means recognising that different people with different levels of advantage will need different approaches and resources to get equitable health outcomes.

Current provisional statistics show that Māori and Pacific peoples are significantly more likely to be put under compulsory mental health treatment than people of other ethnicities. Māori are also five times more likely to be secluded than non-Māori.

Culture of risk aversion

One of the concerns people have about the current Act is that mental health practitioners might seem to make decisions with a focus on reducing or avoiding risk rather than assessing whether the treatment is in the best interest of the patient and delivered in the least restrictive way.

He Ara Oranga recommended a national conversation reconsidering beliefs and attitudes about risk to address these concerns.

Inconsistent with human rights law

Many people and organisations say compulsory mental health treatment doesn't uphold people's rights, including:

- the rights of Māori as tāngata whenua contained in Te Tiriti o Waitangi and their Indigenous peoples' rights to self-determination regarding their health and wellbeing,
- the universal rights of all people to autonomy (independence) and freedom from interference.

A Ministry of Health consultation in 2017 looked into how well the current Mental Health Act upholds human rights. It found that the Act is based on a medical model of mental health, rather than a social model of disability. The review also found that the Act doesn't consider legal capacity (whether a person is able to make choices for themselves) and uses substituted decision-making (where people make decisions for someone else).

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PART 2

Creating a new approach

We are transforming Aotearoa New Zealand's approach to mental wellbeing, building on the vision set by *He Ara Oranga*. Changes to the legislation are one part of this new approach.

Whakamaua: Māori Health Action Plan 2020–2025 and Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing describe an overarching vision of pae ora – healthy futures. Pae ora encompasses three elements: mauri ora (healthy individuals); whānau ora (healthy families) and wai ora (healthy environments).

New mental health legislation can support pae ora by supporting tino rangatiratanga (self-determination), enhancing mana, protecting rights, encouraging whānau involvement, strengthening the recognition of Te Tiriti obligations, and promoting Māori cultural needs and values.

He Ara Oranga gives us a starting place for a vision of future legislation. It says that, at a minimum, the legislation needs to:

- reflect a human rights-based and recovery approach to care
- promote supported decision-making
- minimise compulsory care and coercion (force).

Any new legislation must recognise Te Tiriti and support the rights of Māori as tangata whenua. It must also align with the United Nations Convention on the Rights of Persons with Disabilities.

Grounding in te ao Māori (Māori world view)

We have a unique opportunity to start from scratch and reimagine mental health legislation in Aotearoa New Zealand – what it is used for and when, and how it can support people to be well. With this blank slate, we can design new legislation from a te ao Māori perspective.

This indigenous approach will be a significant shift away from Western, medicalised models of mental health care, treatment, and legislation. A te ao Māori approach would put people at the centre of their care and treatment and include whānau and community.

Guiding principles

We need to make sure new mental health legislation is guided by, and reflects, Te Tiriti o Waitangi. In July 2019, the Government agreed to a set of principles to use when developing new mental health legislation. These are:

- maintaining consistency with Te Tiriti
- taking a human rights approach
- encouraging maximum independence, inclusion in society and the safety of individuals, their whānau and the community
- improving equity of care and treatment
- taking a recovery approach to care and treatment
- providing timely service access and choice
- providing the least restrictive mental health care options
- respecting family and whānau.

A better future for all

He Ara Oranga shows that we need to move away from risk-based approaches to care and treatment (thinking about what might go wrong for a person if they don't get treatment) and instead move to a strengths-based approach that encourages mental health services to actively support the safety of people. The concept of safety needs to be defined by the person rather than the practitioner.

We have an opportunity to create legislation grounded in te ao Māori that will encourage maximum independence and social inclusion for all people.

We need to think about how we provide mental health care that promotes human rights as much as possible, while still keeping individuals, whānau and the community safe.

We can create a new mental health legislation that respects family and whānau, recognises Te Tiriti and improves equity.

The legislation should be a last resort for people in a vulnerable and distressed state: it should not be used as a way for a person to access treatment and services. And the care and treatment provided through legislation should be delivered in a way that recognises a person's strengths.

Embedding Te Tiriti o Waitangi and addressing Māori cultural needs

We want to know how Te Tiriti can be properly recognised in any new legislation as well as what is needed to support Māori cultural needs.



What happens now

The current Mental Health Act does not acknowledge, represent or support te ao Māori or Te Tiriti o Waitangi sufficiently (in legislation or in practice).

The Act says a person's ties with their 'family, whānau, hāpu, iwi and family group' and their cultural and ethnic identity, language, and religious or ethical beliefs should be respected. But there is nothing written in the Act about how practitioners should do this.

Te Tiriti o Waitangi principles

Te Tiriti is our country's foundational document for the relationship between Māori as tāngata whenua and the Crown. This means that legislation and policy should have special regard for the principles of Te Tiriti and for Māori as the Crown's partner through Te Tiriti.

Te Tiriti requires genuine partnership and shared decision-making. The principles of Te Tiriti for health services are described in *Whakamaua: Māori Health Action Plan 2020–2025*. These are **tino rangatiratanga** (self-determination), **partnership**, **active protection**, **options**, and **equity**.

Embedding Te Tiriti o Waitangi and addressing Māori cultural needs

Culture strongly affects how we think about our own and other peoples' lives, relationships, and experiences. It also impacts what we consider to be acceptable/normal or bad/different – as well as our understandings around mental illness and the symptoms of mental distress.

Statistics show that Māori are significantly more likely to be subject to compulsory mental health treatment and seclusion under the current Mental Health Act than non-Māori. Māori people have described their experiences of acute mental health services as 'restrictive', 'disempowering' and aligned to the clinicians' needs rather than their own. They also experienced discrimination due to the stigma of a compulsory treatment order.

Having a strong cultural identity is linked to positive mental health, but being put under the current Act can isolate people, disrupting their relationships and potentially disconnecting them from vital whānau, whenua, and taiao connections.

Legislation that supports Māori cultural needs and values can also ensure better support for all people. Mental health services are encouraged to have kaupapa Māori models of care available, and there are guidelines for the current Mental Health Act that encourage cultural assessment, but these are not requirements in legislation.

What new legislation could do

Recognising Te Tiriti in the new legislation could mean:

- explicitly referencing Te Tiriti in the legislation's purpose and principles
- saying that actions under the legislation must be done in a manner consistent with or in the spirit of Te Tiriti
- setting out specific requirements or giving specific duties to named individuals
- setting out specific requirements for culturally appropriate care for Māori.

Legislation itself will not solve the problem of inequality and inequity. Changes in legislation must be made alongside changes to policy, funding, commissioning, monitoring, and workforce development. We will need to make sure there are clear expectations for mental health providers.

Questions for you

How can legislation help embed Te Tiriti o Waitangi?

What kaupapa Māori principles should the legislation incorporate?

What effect will embedding Te Tiriti o Waitangi into practices have for other population groups (for example, children, disabled people, etc)?

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PART 4

Defining the purpose of mental health legislation

We want to explore why we need mental health legislation in Aotearoa New Zealand. This includes thinking about how legislation should balance different human rights and whether legislation should ever allow a person to be forced to have mental health treatment (compulsory treatment).



What happens now

The long title of the current Mental Health Act sets out the why we have this legislation:

An Act to redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

A person can be given compulsory mental health treatment if they have a mental disorder as defined under the Act and have been assessed that they pose a serious danger of harm to themselves or others or are unable to take care of themselves.

This definition implies that, for a person placed under the Act, concerns about the safety of the person and others outweighs that person's right to accept or reject mental health treatment.

The current Act does not:

- require a person to give informed consent for treatment
- require health practitioners to find out if a person is able to give informed consent to treatment
- clearly say that people should be involved in decisions about their own treatment
- clearly state that compulsory treatment is used only as a last resort.

Human rights and compulsory treatment

People hold several essential human rights, including:

- the right to autonomy
- the right to life and liberty
- the right to be equal before the law and not be discriminated against
- the right not to be tortured or subject to cruel treatment
- the right to health (set out in international law but not established in the laws of Aotearoa New Zealand).

The current Mental Health Act does not eliminate rights, but it does put limitations on the rights of someone placed under compulsory treatment.

Some United Nations committees (including the Human Rights Committee on the Prevention of Torture) have said certain types of compulsory treatment can help protect a person's human rights in some situations.

But the United Nations Committee on the Rights of Persons with Disabilities states that countries should end detention and compulsory treatment based on mental illness or any other disability.

Many countries have updated their mental health laws to take a more human rights approach, but they all continue to have some form of compulsory treatment. You can read more about the different approaches taken by other countries in Appendix B in the Discussion Document.

Balancing the different human rights a person holds

As we develop new legislation for Aotearoa New Zealand, we need to balance a person's rights with the duty to protect the safety of that person if they are in a vulnerable and distressed state.

Sometimes, a person's decision to refuse treatment may make them more unwell or cause them to take aggressive or suicidal actions.

But everyone also has the right to make choices and decisions that others might think unwise, including about their own medical care or treatment.

In Aotearoa New Zealand, people's right to give informed consent, or refusal, to medical treatment is protected in our Bill of Rights and in the Code of Rights.

Another important issue to think about is whether there are times when family, whānau or public concerns are strong enough to overrule a person's right to make their own choices.

Important Te Tiriti o Waitangi and cultural considerations

The concept of individual autonomy (being able to make your own decisions about how you live your life) comes from Western thinking. Some cultures value making decisions collectively with other people more than individual autonomy.

For example, Māori place a high value on the communal relationships within whānau, hāpu and iwi, and in Pacific world views there's a strong focus on working together towards collective wellbeing.

For people who value collective decision-making, being forced into a way of thinking and acting based on individual autonomy can increase mental distress, both for the person and for their whānau and community members.

What new legislation could do

The current Mental Health Act has been criticised for not supporting a recovery approach to mental health. A recovery approach is based on strengths (what people can achieve) rather than deficits (what they may not be able to achieve). Families and whānau may play an important role as part of a person's recovery to become and stay well.

In a recovery approach people should have their mana protected and enhanced, experience respect, engage in shared decision-making and receive support to achieve their health and wellbeing goals.

The new legislation should promote human rights as much as possible, and balance the different rights each person holds, as well as balancing the rights of an individual with the rights of others.

Many people and organisations have criticised compulsory mental health treatment, saying it doesn't uphold people's human rights, including the rights to autonomy and freedom.

Others believe that compulsory treatment for people in a vulnerable and distressed state helps to protect their right to health and health services.

We have heard that some people may be placed under the current Mental Health Act as a way to get treatment, or may ask to stay under the Act to keep getting medication at no cost.

We have also heard that some people may stay under the Act longer than necessary because their clinician is focused on risk rather than the person's wellbeing or recovery.

None of these are good reasons for a person to be placed or kept under compulsory treatment.

New legislation will say whether compulsory mental health treatment should ever be used, and, if it is used, when, where and how it should be used.

Questions for you

What should be the purpose of mental health legislation?

If new legislation does not allow compulsory mental health treatment, what requirements should be in legislation to protect an individual's rights and prevent an individual being coerced into accepting mental health treatment that they might not want?

If legislation allows compulsory mental health treatment:

- What effect might new legislation that does not allow compulsory mental health treatment have for particular population groups (for example, children, disabled people, etc)?
- How might new legislation that does not allow compulsory mental health treatment reflect te ao Māori?
- When should compulsory mental health treatment be allowed?
- How should 'mental disorder' be defined, or do you think another phrase and definition should be used, and if so, what?
- Where should compulsory mental health treatment be allowed to occur (for example, in hospitals and/or community settings and/or other facilities)?
- How might new legislation that allows compulsory mental health treatment reflect te ao Māori?
- What effect might new legislation that allows compulsory mental health treatment have for particular population groups (for example, children, disabled people, etc.)?
- Which health professionals should be allowed to assess whether a person needs compulsory mental health treatment?

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PART 5

Capacity and decision- making

If you think that there are times when compulsory treatment should be allowed, we want to know when it should be allowed.



Whether a person is able to make choices for themselves is called decision-making capacity.

It is a key part of deciding whether compulsory treatment should be allowed, because many other countries only allow compulsory mental health treatment if the person does not have capacity (is not able) to make a decision about their treatment.

There are a lot of important things to consider about this, such as whether risk to themselves or to others should also be included when deciding to place someone under compulsory treatment.

It's also really important to think about how the idea of capacity fits within a te ao Māori perspective, which might align better to a more collective approach.

What happens now

Currently, a person can be placed under the Mental Health Act if it is assessed that their 'abnormal state of mind' poses a risk of 'serious danger' to the health and safety of self or others, or because it 'seriously diminishes' their ability to take care of themselves.

Under the current Act, someone who can make their own decisions (for example, the decision to refuse treatment) can have these decisions overruled by clinicians, even if that person can make that decision for themselves.

A capacity-based approach

Many Aotearoa New Zealand laws start with the belief that a person has decision-making capacity, with exceptions if there's a reason to believe otherwise. There are also protections in place to help people make decisions and to explain what they want (known as supported decision-making).

New Zealand's Code of Rights accepts that a person may lack the capacity to make an informed choice or give informed consent about treatment. There may be another person who is legally allowed to give consent on their behalf, but if not, then treatment can be provided as long as:

- it is in the best interests of the person
- reasonable steps have been taken to find out what the person would like to do
- the health practitioner is reasonably confident the treatment is what the person would choose (often this is in consultation with family or other clinicians)
- it is an emergency or life-saving situation.

The Code of Rights suggests a person should be supported as much as possible to make the decision for themselves.

A person with a severe mental health condition may still have capacity to make decisions about their treatment, even if this capacity changes from one day to the next.

One option is for a health practitioner to make a 'capacity assessment' of a person's decision-making process. A person is generally able to give informed consent to a decision if they:

- understand the information given to them about the decision
- can remember the information
- can weigh up the information
- can communicate their choice.

For people with both a mental illness and another disability, such as a learning or physical disability, it's really important that the same capacity assessment principles apply.

If we say that someone can only be placed under compulsory treatment if they can't make an informed decision about their treatment, then we need to be clear about what happens when that person recovers capacity.

Cultural considerations

It's important to think about how a capacity test would fit with te ao Māori, as some Māori mental health clinicians have said that capacity (the ability to make decisions for yourself) should be balanced with the concept of whānau and community.

For example, Māori could take a more collective approach to understanding the preferences of someone who may need compulsory mental health treatment.

One model for making decisions in the best interest of someone unable to make informed decisions about their care while also including family, whānau, and culture is the family group conference model used by Oranga Tamariki. There may be lessons from the model that could be used in a mental health setting.

The use of 'risk' as additional criteria for compulsory assessment and treatment

Some countries use other criteria as well as decision-making capacity to place a person under compulsory treatment. Examples include:

- whether there could be serious risks to the safety of the person or others
- whether there is a less restrictive alternative
- whether the person's physical or mental state is likely to get worse.

Concerns with a 'predictive approach' to assessing risk

The new legislation gives us the chance to think about when and how – if ever – compulsory treatment could be used when it appears that someone is at risk of harming themselves or others.

Evidence shows it is very difficult to predict the outcomes of treatment in psychiatry, and there is not necessarily a connection between mental disorder and a person in danger of hurting themselves or others.

There may be a small minority of people whose mental health poses a risk to others, but for most people with severe mental illness, 'violence is no more predictable in them than in those without mental illness' (Szmukler 2019).

This evidence is important in the discussion around compulsory treatment because there are significant consequences for a person when they are assessed as being a risk to themselves or others.

The social belief linking mental disorder with dangerousness can increase stigma, which can lead to people not accessing care early for fear of what might happen or what others might think of them, or their family or whānau.

What new legislation could do

If compulsory treatment is allowed, the legislation must clearly say when that treatment would be allowed. The legislation could say:

- whether a person must lack capacity and/or any other requirements that must be met before compulsory treatment would be allowed
- when compulsory treatment must stop.

Given the stigma and discrimination that can be experienced by people subject to compulsory treatment, it is important that the rules around when compulsory treatment can be used are clear, so there is less room for different practices between clinicians.

Questions for you

What criteria should the legislation use to say when compulsory mental health treatment is allowed?

If decision-making capacity is a criterion, what matters should be relevant to an assessment of whether a person has the capacity for the purposes of mental health legislation?

Who should assess whether a person has the capacity to make a decision about mental health treatment?

If additional criteria for when compulsory assessment and treatment can be used are related to risk, how should these criteria be framed?

How would the criteria for compulsory mental health treatment reflect te ao Māori?

How should the legislation address cultural considerations in the requirements for when compulsory mental health treatment can be used?

How would the criteria for compulsory mental health treatment affect particular population groups (for example, children, disabled people, etc)?

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PART 6

Supporting people to make decisions

We want to find out how legislation can ensure people are supported to make their own decisions about mental health and treatment.



This part deals with what should be included in the legislation to make sure people are supported to make their own decisions about their treatment. Even if you do not believe compulsory treatment should be allowed, this part is still important because people will need support to make their own decisions at times.

Supported decision-making means providing a person with the help they need to allow them to make decisions about their treatment, care, or support.

New legislation could offer a range of supports to help people make their own decisions, and could say if or when whānau should be involved.

What happens now

The current Mental Health Act uses substituted decision-making. Substituted decision-making is when someone makes a decision for another person. It might not be the decision the person would have made.

The current Act does not say people must be supported to make a decision about their own mental health treatment, but it also doesn't say supported decision-making tools can't be used.

What is supported decision-making?

Supported decision-making means giving a person the help they need to allow them to make decisions about their own treatment, care or support.

It is different from substituted decision-making, where specific people, such as guardians, can make decisions for someone. It is also different from shared decision-making, where people and their treating team make decisions together about treatment.

The Code of Rights suggests a person should be supported as much as possible to make their own health treatment decisions.

The United Nations Convention on the Rights of Persons with Disabilities states under Article 12 that all disabled people, including those with mental illness, have the right to control decisions about their lives, with whatever support they need.

There are some key tools used to help with supported decision-making by people with severe mental illness. These include advance directives, nominated people and independent advocates. One or more of these tools could be included in the new legislation. Family, whānau and friends can be part of a person's support when it comes to decision-making.

We want to know what role supported decision-making should play in the new legislation, and what tools or processes people could use. We also want to know whether a decision made with supported decision-making could ever be overturned.

Questions for you

What should be the role of supported decision-making in mental health legislation?

How might a supported decision-making process reflect te ao Māori?

What supported decision-making tools or processes, if any, should the legislation enable people to use?

When, if ever, should the legislation allow a decision made through a supported decision-making process to be overridden?

What effect would supported decision-making have for particular population groups (for example, children, disabled people, etc)?

Seclusion, restraint and other restrictive practices

We want to find out whether new legislation should ever allow the use of seclusion, restraint, or other restrictive practices, and if so, how legislation can ensure people's rights are protected and the use is appropriately limited.

Seclusion is when a person is placed alone in a locked room. The Ministry of Health has committed to the goal of reducing and eventually eliminating seclusion.

This is particularly important if we are going to embed Te Tiriti principles in mental health legislation, as reporting shows that Māori are five times more likely to be secluded than non-Māori.

In 2019, around 10 percent of people in adult mental health inpatient services were secluded at some stage, but the rates varied widely across DHBs. Aotearoa New Zealand has been criticised for high rates of seclusion and restraint.

He Ara Oranga stated that seclusion and restraint are used too often, especially for Māori, and seclusion can contribute to peoples' experience of harm, trauma, and powerlessness.

However, some people say not being able to use seclusion and restraint might make staff and people using services unsafe and could lead to clinicians using sedating medication instead.

While changing the legislation will help to reduce the use of restraint and seclusion in mental health services, we also know more work is needed to support any changes, especially in training, staffing levels, and improving mental health facilities.

What happens now

The current Mental Health Act allows for people under the Act to be secluded.

Only people under an inpatient compulsory order can be secluded, and only with the authority of the person's responsible clinician (except in an emergency).

People can only be secluded in certain rooms, and there is a register noting why and for how long a person was secluded.

The current Mental Health Act does not specifically allow a person to be restrained, but it says force can be used 'when exercising other powers under the Act'.

The current Mental Health Act also allows a medical practitioner to give a person sedative medication if they believe that person is a significant danger to themselves or others, and it is in the best interests of the person.

What new legislation could do

New legislation could say whether seclusion, restraint, or other restrictive practices could ever be used, when and how they could be used, and how to make sure people are protected.

Questions for you

What, if any, restrictive practices should the legislation allow?

How should legislation ensure the use or prohibition of restrictive practices reflects te ao Māori?

If any restrictive practices are allowed, what rules should be in the legislation about their use?

What rules should legislation include to ensure patients and staff are safe whether or not restrictive practices are allowed?

What effect would allowing or prohibiting restrictive practices have for particular population groups (for example, children, disabled people, etc)?

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PART 8

Addressing specific population group needs

We want to find out how new legislation should address the specific needs of different population groups.

The impact of new mental health legislation on some groups will need to be carefully considered.

Addressing cultural needs

We want to know what is needed in legislation to ensure people receive culturally appropriate care.

The current Mental Health Act says that all powers and proceedings under the Act must recognise a person's cultural or ethnic identity, but it does not give clear guidance about how this should be done.

New legislation could include specific requirements for cultural models of care to be used, high-level general requirements, or a combination of both.

Questions for you

What is needed in legislation to ensure people receive culturally appropriate care?

How would addressing culturally appropriate care in the legislation reflect te ao Māori?

How might addressing culturally appropriate care in the legislation affect particular population groups (for example, children, disabled people, etc)?

Respecting families and whānau

Whānau can be important in supporting a person through illness, diagnosis, treatment, and recovery. Additionally, having a family member under the Act can have significant impacts on that whānau.

While there are many different ways to define family and whānau, the most important perspective is that of the person receiving mental health care.

The current Mental Health Act says whānau should be consulted, but in practice this does not always happen in consistent ways.

Including family and whānau in meetings with clinicians can make a difference – families know what is happening for their family member and the clinician can get a fuller picture of a person's health situation.

However, finding the right balance between the wishes of a person and those of their family, whānau, āiga and carers can be difficult.

We want to know when, if ever, family and whānau should be included in the care and treatment process and how this should be done. We also want to know when it is acceptable not to include family and whānau, and whether there is any information that must or must not be shared with family and whānau.

Questions for you

How, if ever, should legislation require the involvement of family and whānau, where appropriate?

How would any requirements for family and whānau involvement reflect te ao Māori?

What rights and responsibilities should family and whānau be given in the legislation?

When is it appropriate not to require the involvement of family and whānau?

What information, if any, should legislation require to be shared with family and whānau?

Children and young people

We want to know how compulsory treatment should be applied to children and young people, what level of involvement family and whānau should have, and what the process should be if staff and family and whānau disagree on treatment.

The current Mental Health Act applies to people of any age. Children and young people have all the same rights and protections as adults under the Act, and some additional requirements such as having access to a psychiatrist with expertise in child psychiatry “if practicable”.

The current Act says that a child or young person’s principal caregiver must be informed and consulted on assessment and treatment decisions for the young person.

Young people aged 16 and over can be involved in making decisions around their treatment but, like adults under the Act, this can be overruled. For children and young people under 16, the responsible clinician (rather than parent or guardian) makes treatment decisions.

In 2020, there were 433 children and young people aged 17 years or younger under the Mental Health Act. Of these, 191 were Māori (44 percent).

We have little information directly from children and young people on how they feel about their experiences of compulsory treatment.

Any new mental health law must include special considerations for children and young people, and also consider the Care of Children Act 2004 (which gives a young person who is 16 years or over the right to agree to or refuse medical treatment, without the need for parental involvement).

Whatever the situation, it’s really important that the child or young person is supported to express their views, and their perspective is considered. We also need to think about the role of family, whānau, hāpu and iwi when developing the new legislation.

Questions for you

How should compulsory treatment be applied to children and young people?

How would mental health legislation specific to children and young people reflect te ao Māori?

How should legislation require family and whānau be involved in situations that relate to children and young people?

What should the process be when staff and family and whānau disagree on treatment for children or young people?

What should supported decision-making look like for children and young people?

Disabled people

We want to know what, if any, specific requirements and/or protections should be included in the legislation to make sure the particular needs of disabled people are met, and whether any specific reporting and monitoring is needed.


In general, disabled people have poorer health outcomes than non-disabled people and often have other health conditions that affect their quality of life. Māori disabled people and their whānau, Pacific disabled people and their āiga, and people with an intellectual/learning disability all experience worse outcomes than any other group of disabled people.

Apart from saying an interpreter must be provided if required, the current Act does not include any more protections for people with disabilities who are placed under the Act.


A person **cannot** be subjected to the compulsory assessment and treatment process just because they have an intellectual disability.

It is possible for a person to have an intellectual disability and a mental health condition. If the person is 'mentally disordered' then compulsory assessment and treatment may be used.

Questions for you



What, if any, specific requirements should legislation include regarding disabled people?



How would any specific legislative requirements regarding disabled people reflect te ao Māori?

People within the justice system (special patients)

We want to know whether compulsory mental health treatment should be allowed for people in the justice system and, if so, under what circumstances.

The Criminal Procedure (Mentally Impaired Persons) Act 2003 allows courts to find someone being charged with a crime either not guilty by reason of insanity, or unfit to stand trial. These people then become special patients under the Mental Health Act and receive mental health treatment in a secure environment.

People who have been found unfit to stand trial may be referred back to the court once they are assessed as being well enough to stand trial. They may then be released, convicted and sentenced, or found not guilty by reason of insanity and once again made a special patient.

Special patients do not lose their essential human rights. While a person's behaviour may give a legitimate reason for limiting their right to freedom, it does not necessarily limit other rights, such as the right to give consent to treatment.

Currently, special patients are released only if they accept treatment and both their mental disorder and their risk of reoffending resolves or becomes minimal. If the new legislation only allows compulsory treatment when a person does not have the ability to make decisions about their own care, conditions for release from special patient status will need to be redefined.

Potentially the most complicated situation to consider and address in new legislation is when someone is found not guilty by reason of insanity. Currently, someone found not guilty by reason of insanity does not receive any specified length of detention. Instead, the person is made a special patient under the current Mental Health Act with no defined length of time attached to their order.

New legislation could say what should happen when a person with decision-making capacity in the justice system does not want to receive mental health treatment, and how compulsory mental health treatment should apply for a person found not guilty by reason of insanity.

Questions for you

How should the legislation treat a person with decision-making capacity in the justice system who does not want to receive mental health treatment?

How would legislative requirements relating to people in the justice system reflect te ao Māori?

How should compulsory mental health treatment be applied for a person found not guilty by reason of insanity?

Would legislative requirements relating to people in the justice system affect particular population groups (for example, children, disabled people, etc), and if so, how?

Protecting and monitoring people's rights

We want to know what changes might be needed to strengthen and improve the protection of people's rights under new mental health legislation.



If new legislation continues to allow for compulsory mental health assessment and treatment, then there must also be ways to make sure people are protected. This includes having fair and transparent legal processes, ways to regularly review compulsory treatment, and the ability to challenge compulsory treatment decisions.

Court, tribunal and other legal processes

The current Mental Health Act states that compulsory treatment order applications and extensions should be heard by a Family Court judge whenever possible. A Family Court judge decides if the person should be placed under a compulsory treatment order after compulsory assessment.

If a person disagrees with a clinical decision or review, they can apply to the Mental Health Review Tribunal to see whether they should stay under the Act.

Each sitting tribunal is made up of at least one psychiatrist, one lawyer and a community member. If a person disagrees with the tribunal's decision, they may appeal to the District Court.

People have said that their experience of the District Court and the Mental Health Review Tribunal was confusing and disempowering and did not support people to improve their mental wellbeing.

Some people have raised concerns that judges rely too heavily on clinical advice over information from family and whānau, kaumātua or kuia.

Concerns have also been raised about the lack of cultural support for people experiencing Court proceedings under the Act.

The legal criteria for discharge from the current Mental Health Act has also been criticised on the grounds that the Act makes it harder for a person to be released from the Act than it does for a person to be placed under the Act.

New legislation could say who has the power to approve the use of compulsory mental health treatment, and the process for this to happen. Legislation should also clearly describe the process a person would follow to challenge a decision.

Questions for you

Who should be responsible for approving the use of compulsory mental health treatment?

What should be the process for approving the use of compulsory mental health treatment?

What information should be required for requests to approve the use of compulsory mental health treatment?

How would the process for approving compulsory mental health treatment reflect te ao Māori?

What supports could be made available to make it easier for people to engage with the process for approving the use of compulsory mental health treatment?

What would be the effect for particular population groups (for example, children, disabled people, etc) of having either the District Court or a tribunal responsible for approving the use of compulsory mental health treatment?

Challenging clinical decisions

Under the current Mental Health Act, a person must receive the treatment that their responsible clinician prescribes during the first month of compulsory treatment even if they don't want or agree to the treatment.

After that month, the person must consent (agree) to treatment in writing. But treatment can still be given without consent (over-ruling the wishes of the person receiving treatment) if another psychiatrist considers the treatment to be 'in the interests' of the patient.

People have said that because the mental health service is able to override someone's decisions, refusing to give consent is often little more than a symbolic protest.

Concerns have been raised that psychiatrists providing second opinions are not always perceived to be independent from the responsible clinician.

There is nothing in the current Act that says what should happen when the responsible clinician and the second psychiatrist disagree. Often, a different psychiatrist may be asked to give a new second opinion, meaning the responsible clinician essentially avoids the clinical disagreement.

New legislation could include a clear process for what a person can do when they don't agree with the treatment chosen by a practitioner.



Questions for you

What should the process be when a person disagrees with the compulsory mental health treatment chosen for them by a health practitioner?

Under what circumstances should a health practitioner be able to override a person's decision about a particular treatment if the person is under compulsory treatment?



The role of police


The current Mental Health Act allows police to assist in detaining (holding or restraining) a person:

- in a public place, if the police have a reasonable belief that the person meets the definition of mentally disordered under the Act
- at a private place if a medical practitioner or duly authorised officer requests assistance.

The current Mental Health Act allows police to detain a person for up to six hours while arrangements are made for the person to be assessed under the Act. A person who is waiting for an examination may be detained in an emergency department or in police cells.

It is possible that involving police when people need mental health assistance further promotes stigma and criminalisation of people with mental health needs.

Questions for you



What role, if any, should police have in the new legislation?

Monitoring individuals' rights

The current Mental Health Act includes several different roles responsible for making sure people's rights under the Act are upheld. These include:

- **Directors of Area Mental Health Services:** These people make sure the Act is being followed at each service or facility. They must provide reports on the use of the Act every three months.
- **District inspectors:** These are lawyers appointed to help people who are being assessed or treated under the Act. They provide information and support to make sure the patient's rights are upheld and also monitor the quality and safety of mental health services.
- **Duly authorised officers:** These are mental health professionals who help people going through the compulsory assessment and treatment order process.
- **Director of Mental Health and Addiction Services:** This person is responsible for monitoring the use of the current Mental Health Act across Aotearoa New Zealand. They can also start an inquiry if serious issues are identified through reporting and/or complaints.

Anyone, including a person under the Act and their family and whānau, can make a complaint to a district inspector. After talking with the person, the district inspector may choose to investigate and report the matter to the mental health service.

If the person is unhappy with the results of the investigation, they can take their complaint to the Mental Health Review Tribunal.

Beyond making a complaint to a district inspector, the current Mental Health Act does not include any other specific complaints processes.

However, people under the current Mental Health Act have a range of options for making formal complaints, including:

- complaining to the health service or district health board
- complaining to the Health and Disability Commissioner
- complaining about district inspectors to the Director of Mental Health and Addiction Services
- complaining about police conduct through the Independent Police Conduct Authority.


Some people have suggested that the current complaints process, involving multiple organisations, is confusing and difficult to follow.

New legislation could create specific roles with clear responsibilities to make sure people's rights are protected. Legislation could also include reporting requirements, and a clear complaints process.


Questions for you



What monitoring and oversight roles should be created in new legislation?



What should be the powers and responsibilities of these roles?



What should be the complaints process for compulsory mental health treatment?



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