MANATŪ HAUORA
MINISTRY OF HEALTH

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11 January 2023

s 9(2)(a)

By email: s 9(2)(a)
Ref: H2022017874

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to Manatū Hauora (the Ministry of Health) on 29 November 2022 for information regarding amendments to the Mental Health Act. I will respond to each of your requests in turn. You requested:

> *Would be interested to learn the various selected people whom are on the expert advisory panel.(in assisting this topic)*

The members of the Mental Health Act Expert Advisory Group are:

- Co-Chairs: Anthony O'Brien and Kerri Butler
- Frank Bristol
- Gemma Griffin
- Karaitiana Tickell
- Kiri Prentice
- Mark Fisher
- Patsy-Jane Tarrant
- Raeleen Toia
- Tereo Siataga-Kimiia
- Tui Taurua
- Wheeti Maipi

Further information about the repeal and replacement of the Mental Health Act, including members of the Expert Advisory Group, is publicly available at: www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/repealing-and-replacing-mental-health-act.

> *What additional inclusion on this future proposed legislation would fully support all the objectives in the “NZ Disability Strategy”.*
>
> *What additional inclusion on this future proposed legislation would also support the “UN Convention for the Rights of all People with a Disability”.*

While Cabinet has not yet made final decisions about the details of new mental health legislation, in June 2019, Cabinet agreed to a set of high-level principles to guide the policy development for new legislation:

- Taking a human rights approach
- Maximum independence; inclusion in society; and safety of individuals, their whānau, and the community
- Recognition and incorporation of, and respect for, the principles of Te Tiriti o Waitangi
- Improved equity of care and treatment
- Recovery approach to care and treatment
- Timely service access and choice
- Provision of least restrictive mental health care
- Respect for family and whānau.

These principles provide a clear direction that new mental health legislation will need to reflect a human rights-based approach and align more strongly with the rights set out in the United Nations Conventions for the Rights of People with Disabilities. These principles also set the expectation that new mental health legislation must promote supported decision-making, align with recovery and wellbeing models and minimise compulsory treatment.

> *Finally, would deeply appreciate (as an OIA Request) the sending of a hard copy of all lodged submissions, together with the summary document etc.(a NZ Government publication) as unfortunately (mainly because of a continual lack in adequate resources) don’t possess the availability of an a appropriate printing device.*

Manatū Hauora received around 317 written submissions in response to the public consultation on the repeal and replacement of the Mental Health Act. Of these, 155 were submitted online through the Health Consultation Hub, and the rest were received by email. Many submissions were made by individuals. Manatū Hauora also received submissions from organisations. Some organisations may have chosen to make their submissions available on their websites.

An independent research and evaluation provider has analysed all the submissions. This resulted in a submissions analysis document, which provided information on the range of submitters and the key themes raised through the public consultation process. This document also enables the feedback to be shared with the public in a manner that does not identify individuals who have shared their personal experiences.

Due to the personal information included within individual submissions, information within scope of this part of your request has been withheld under section 9(2)(a) of the Act, to protect the privacy of natural persons. I have considered the countervailing public interest in releasing information and consider that it does not outweigh the need to withhold at this time. However, please find enclosed as Appendix 1 the summary document, which is also available at: https://www.health.govt.nz/publication/repealing-and-replacing-mental-health-act-analysis-public-consultation-submissions.

I trust this information fulfils your request. Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Manatū Hauora website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Kiri Richards

Kiri Richards
Acting Associate Deputy Director-General
Mental Health and Addiction
System Performance Monitoring | Te Pou Mahi Pūnaha

Appendix 1

Kaitiaki Research and Evaluation

Repealing and Replacing the Mental Health Act: Analysis of Public Consultation Submissions

prepared for

Ministry of Health Manatū Hauora

by

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May 2022

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EXECUTIVE SUMMARY

INTRODUCTION

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) sets out the specific circumstances in which people may be subject to compulsory mental health assessment and treatment.

As part of the response to *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*, the Government agreed to the recommendation to repeal and replace the Mental Health Act so that it 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.

Since 2019, the Ministry of Health has been developing immediate and short-term improvements under the current legislation, alongside work to understand what issues need to be addressed in creating new mental health legislation for Aotearoa New Zealand.

The Ministry of Health conducted public consultation between 22 October 2021 to 28 January 2022, on the repeal and replacement of the Mental Health Act to inform the development of policy proposals for new legislation.

The public consultation involved two consultation channels.

- Written submissions.
- A number of targeted consultation hui, including people with lived experience, Māori, Pasifika, and communities of interest.

This document reports on the outcome of public consultation. The Ministry of Health contracted Kaitiaki Research and Evaluation (Kaitiaki) to undertake the analysis of feedback and submissions received through the public consultation process. This process is intended to ensure that the analysis of submissions was independent of the Ministry. The analysis represents the views of submitters and stakeholders who took part in the public consultation and does not represent the views of Kaitiaki or the Ministry of Health. For the sake of clarity when we use ‘we’ this refers to Kaitiaki Research.

METHODOLOGY

The Ministry of Health developed the approach and format of the consultation hui in collaboration with tāngata whaiora, including both Māori and tauiwi.

Written submissions were able to be provided in various ways. A total of 317 written submissions were received, of those:

- 155 specifically responding to questions through the Ministry of Health's consultation hub; and,
- 162 submissions from individuals and organisations were provided by email.

In addition, over 500 people attended approximately 60 online consultation information and hui sessions which, on average, lasted two hours. Due to COVID-19, all sessions were facilitated online via Zoom.

At the completion of the public consultation, all written submissions and consultation hui feedback were provided to Kaitiaki for analysis.

The written submissions and the consultation hui were analysed separately. While there was divergence of viewpoints within people's responses, where clear positions were taken there was a high degree of consistency across the themes arising from the two consultation processes. Such consistency has provided a high degree of validation in the analysis and the interweaving of the two processes within the document.

CONTEXTUAL ISSUES

While the aim of the consultation was to elicit perspectives on the repeal and replacement of the Mental Health Act, the majority of submissions and comments from the consultation hui raised issues, concerns and suggestions that provide contextual information underpinning why stakeholders consider the repeal and replacement of the Act is important. Not all these issues are able to be addressed through legislation, however, these perspectives provide context for the repeal and replacement of the Mental Health Act and to provide foundational insights to inform the development of any legislation.

Misuse of the Mental Health Act

Through the feedback received, we heard that the Act has been misused in the following ways:

- as a punitive measure and to force an individual to receive treatment. Both facets were described as resulting in trauma and this was especially noted for disabled people;
- the Act is sufficiently ambiguous to result in varied and inconsistent application;
- people are being brought or are staying under the Act to access treatment and services that would not otherwise be available; and,
- accounts were offered of how hard it can be, or how long it can take, to come under the Act, with consequences such as near death and shattered lives.

Environment

Stakeholders considered that acute inpatient environments can exacerbate someone's distress and mental health legislation should require inpatient settings to be designed to reflect therapeutic and supportive environments.

Paradigm shift is required

An overarching view was that a paradigm shift is required to shift from an acute and crisis response to a focus on prevention, and the provision of early engagement with comprehensive services. It was considered that such a paradigmatic shift would:

- reduce the risk of escalating mental distress that might result in the individual coming under the Act;
- require a shift in focus away from the singular privileging of psychiatry;
- require increased resourcing and address current levels of gross under-resourcing;
- require a shift in focus from detention to holistic and person-centred treatment and in- and out-of-inpatient services so the individual can return home sooner. Within this context we also heard that the provision of ongoing support is essential; and,
- regard compulsory treatment as a last resort and that other alternatives to the Act should be tried first.

Tino rangatiratanga, kāwanatanga and partnership

Concern was raised that the current crisis in mental health responsiveness has coincided with an erosion of kaupapa Māori services working in mental health and addiction settings.

Across stakeholders, two primary perspectives were identified:

- the first cohort spoke strongly about the need to embed Te Tiriti within new mental health legislation. This cohort, from written submissions and consultation hui, stressed that Te Tiriti embedded legislation establishes a requirement for legislation, related policy and practice, to be co-developed and written in partnership with mana whenua; inclusive of tāngata whaiora.
- the second cohort stressed that the wellbeing of tāngata whaiora and their whānau can only be achieved by devolving service provision to Iwi, hapū, Māori community-based service providers and kaupapa Māori services.

The centrality of family, whānau and significant others

Across stakeholders, family and whānau were described as essential to the wellbeing of tāngata whaiora with the need to acknowledge family, whānau and significant others as a central component of the distressed individual's wellbeing. Within this context it is important to give paramountcy to the wishes of tāngata whaiora about the inclusion of family or whānau, and to protect the tāngata whaiora.

WIDER SYSTEM AND OPERATIONAL MATTERS

Participants commonly raised issues and made recommendations that addressed operational rather than legislative considerations. Many of these are considered essential to facilitate necessary legislative and wider system transformational change. The issues and recommendations are presented here to inform the ongoing work to transform the mental health and addiction system, including the development of the Mental Health and Addiction System and Service Framework. Commonly raised feedback encompassed the need to:

- improve support for family, whānau and significant others;
- develop and increase the peer and cultural support workforce;
- invest in workforce leadership, development, and training;
- grow the Māori mental health workforce, and the workforce in general to meet need;
- address racist and discriminatory practice;
- establish effective monitoring and accountability;
- establish effective debriefing processes for post-compulsory treatment planning and care; and,
- significantly improve care and treatment environments.

SHOULD THERE BE COMPULSION?

Many stakeholders shared a desire for the removal of compulsory treatment from mental health legislation. Of these, most however, did not believe removal is possible at present due to the current design and focus of mental health services. In this sense, no compulsion was viewed as aspirational.

The majority of those participating in the consultation hui agreed that mental health legislation should include the limited use of compulsion, but that legislation should stress that compulsion is a last resort only.

Perspectives on whether or not there should be compulsion fell into two distinct cohorts. This section addresses the often-competing perspectives.

Those in favour of significant reductions or total removal of compulsion

Those who supported the removal of compulsion from legislation referenced the following systemic problems:

- the incompatibility of compulsion within a human rights framework, that non-consensual treatment and involuntary detention is a breach of UNCRPD and that new legislation continuing with this would be a serious breach of obligations;
- compulsion does not align with te ao Māori and Pacific worldviews;
- the way society, inclusive of clinicians, views mental distress, which can lead to misdiagnosis and use of the Act. This was especially noted for Māori;

- a reliance on dominant western biomedical psychiatric models has resulted in a singular privileging of psychiatry;
- there is a need to shift mental health legislation from a singular crisis intervention focus to ensure universal engagement, early intervention, treatment, recovery and holistic support of tāngata whaiora; and,
- that tāngata whaiora Māori and their whānau would be better supported by the equivalent choice of kaupapa Māori services and that service provision should be devolved to Iwi Māori and kaupapa Māori services.

Those who are cautious about or opposed to a complete removal of compulsion

We heard support for the inclusion of compulsory treatment in mental health legislation because of a concern that:

- the removal of compulsion may leave some people unwell, vulnerable, homeless, and unable to care for themselves, with the risk of inhumanely not treating an individual and possibly leading to increased suicidality and death.
- tāngata whaiora who are not aware of their need for treatment will remain untreated while simultaneously being a risk to themselves or others and decline in their health and wellbeing;
- without appropriate mental health legislation there is a risk of people entering the criminal justice system, as opposed to being assisted by the health system; and,
- a lack of compulsion could result in extra pressure being placed on families.

Areas of consensus

Despite the above differences, the two cohorts agreed:

- it is important to implement compulsory treatment orders without adversely affecting the individual;
- legislation should advance supported decision-making, particularly advance directives (in place of substituted decision-making) as a means of empowering tāngata whaiora and ensuring their rights and wishes are followed; and,
- some degree of compulsion might be required when someone has no previous mental health diagnosis and suddenly experiences an acute mental health crisis.

IF THERE WAS SOME COMPULSION, WHAT WOULD IT LOOK LIKE?

When and where should compulsory treatment be allowed

Participants considered that compulsion should only be allowed as an option of last resort. This would mean that criteria for compulsory treatment under mental health legislation should reflect extreme and serious circumstances and where no other option exists. Participants offered suggested compulsory criteria and core principles to inform the new mental health legislation.

There was consensus that there should be a range of settings and options available to tāngata whaiora (and their whānau) that provide the most appropriate treatment support.

Which health professionals should be allowed to assess whether a person needs compulsory mental health treatment?

Participants identified a range of mental health and health professionals that should be allowed to assess the need for compulsory mental health treatment. There was no particular consensus on any one specific health professional. Commonly participants considered it was important that:

- assessment involve a group or multidisciplinary team approach (and should not be an individual decision); and,
- there is involvement of family, whānau and significant others in the assessment process.

We heard that those undertaking the assessment should be trained, culturally safe, and experienced and specialised in assessment, including crisis assessment.

Safeguards

Participants identified a range of checks and protections that they considered are required in any new mental health legislation.

Rights of tāngata whaiora

Stakeholders consider that legislation should explicitly state that:

- tāngata whaiora are entitled to the provision of full information to enable them to participate in decision-making processes, to make fully informed decisions, and to ensure informed consent. This includes the right to choose and refuse treatment based on full information, and to be fully informed about the process and what will happen, as well as the benefits and disadvantages of different decisions;
- tāngata whaiora Māori, whānau, hapū, and Iwi should be fully informed and empowered to participate in assessment processes and to be a part of decision-making; and,
- decisions surrounding intervention should align with an individual's wishes, as outlined in advance directives.

Monitoring and reviews

A number of recommendations were identified for monitoring and review, these included:

- treatment should be independently reviewed to ensure it adheres to best practice;
- family, whānau and significant others should be given the right to "audit" services;
- second opinions should be independent;
- there should be timely investigations of complaints or issues as they arise; and,
- clinicians needing to evidence their prescribed treatment in accordance with best practice.

Limitations

Stakeholders identified that legislation should explicitly time limit compulsion and require it to be of a shorter duration.

Tāngata whaiora always supported

Participants outlined that tāngata whaiora should always have:

- easy access to proactively offered peer and cultural support, including independent advocates;
- the right to access cultural and spiritual supports from the outset and across the spectrum of treatment (including kaumātua, tohunga, kaiawhina); and,
- automatic provision of cultural care and support.

Centrality of family, whānau and significant others

Participants spoke of the significance of family, whānau and significant others to the wellbeing of tāngata whaiora, it was identified that:

- whānau are essential to the wellbeing of tāngata whaiora;
- a holistic focus means that a collective notion of self needs to be included in mental health legislation to reflect whānau as an essential component of engagement, decision-making, advocacy and support;
- legislation should acknowledge that the wishes of tāngata whaiora about the inclusion of whānau should be paramount;
- legislation should explicitly allow for significant others, as defined by tāngata whaiora, to be part of the decision-making process;
- legislation should include provision to support the whānau;
- for tāngata whaiora Māori, whānau, hapū, and Iwi should be fully informed and empowered to participate in assessment processes and to be a part of decision-making;

Provision for culturally appropriate responses

A range of views were shared on how legislation could be more culturally appropriate, including:

- the inclusion of the perspectives of whānau and those with cultural expertise is necessary to ensure sufficient context is provided to contribute to appropriate decision-making;
- a model of care needs to be implemented that is founded upon respect, time taken to know the individual and understanding their life course (whakapapa) and needs;
- tāngata whaiora Māori should have the choice of western or Māori approaches and Māori healing practices; and,
- mental health needs to be understood and responded to from a te ao Māori perspective and within the context of Māori models of health.

Cultural assessment

Stakeholders emphasised the need for increased use of cultural assessments. Mental health legislation should:

- require the provision of such assessments and such provision should be linked to protection-related Treaty obligations;
- require cultural assessments to be considered in all decision-making, equitably against psychiatric assessments;
- specify a quality standard that cultural assessments need to attain;
- require cultural assessments to be holistic and include psychological, cultural, and spiritual considerations; and,
- include provision for increased resourcing to ensure cultural assessments are conducted to a high standard and undertaken by culturally competent practitioners.

Court engagement

Participants identified that judicial processes need to be person and whānau-centred and above all adhere to mana enhancing practices. Mental health legislation should make provision for such practices.

Mental health workforce

We heard that legislation should require:

- mental health providers to demonstrate cultural competency; and,
- tāngata whaiora Māori should have access to Māori practitioners skilled and knowledgeable in te ao Māori and te reo Māori to ensure cultural perspectives are brought to care, assessment, treatment, and support, and to ensure cultural appropriateness.

PREVENTING COERCION IF COMPULSORY TREATMENT IS NOT ALLOWED

Submitters were asked what requirements should be in legislation to prevent an individual being coerced into accepting mental health treatment they might not want. While responses varied, key themes that emerged related to the need for:

- adherence to a human rights framework;
- provision of adequate supports;
- whānau to have an integral role in supported decision-making;
- community-based support and treatment options; and,
- legislated advance directives.

TE TIRITI O WAITANGI

The importance of embedding the articles, principles, and intent, of Te Tiriti o Waitangi (Te Tiriti) in all aspects of new mental health legislation was commonly shared. In particular the need to:

- explicitly reference the articles and principles of Te Tiriti ;
- clearly determine how these articles and principles will be embedded across the legislation;
- articulate what this means in practice, namely expectations, required actions and accountabilities; and,
- ensure legislation is grounded in te ao Māori.

In addition, it was strongly suggested that:

- legislation should be co-created and written in partnership with Māori and tāngata whaiora;
- legislation acknowledge the integral relationship between Te Tiriti, kawanatanga, tino rangatiratanga and ōritetanga and the person's connection with their wairua, values and beliefs from a Māori worldview;
- legislation should be drafted with reference to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP);
- Te Tiriti, if correctly embedded within the legislation, would simultaneously benefit tauiwi (non-Māori) by reinforcing holistic approaches to wellbeing;
- through embedding the principle of partnership, new mental health legislation will provide an essential opportunity for tāngata whaiora Māori to actively participate in the ongoing development of mental health responsiveness;
- Te Tiriti should be embedded into guidelines arising from mental health legislation to guide implementation;
- adherence to the principle of equity, and the achievement of equitable outcomes for Māori, requires appropriate resourcing;
- there needs to be appropriate checks and balances to monitor and ensure mātauranga Māori and Te Tiriti articles and principles and requirements are being honoured.

Rather than a last resort mental health option, we heard that the focus of mental health legislation should be about supporting tāngata whaiora in the widest sense of their wellbeing, beyond a simplistic notion of mental health. To achieve this a number of central te ao Māori tenets (inclusive of include Tiriti principles and aspects of the articles of Te Tiriti) were identified (see Table 8.1).

CAPACITY AND DECISION-MAKING

There were mixed views about the need for a test of capacity as an element of compulsory treatment. From the majority of participants, however, we heard support for the introduction of a test of decision-making capacity.

Considerations by those supporting the inclusion of capacity

- definitions of capacity need to be aligned across legislation, for example, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and Protection of Personal Property Rights Act 1998;
- at a minimum, capacity should be an integral component of the assessment process;
- new mental health legislation should require capacity to be reviewed at regular intervals and consider how a clinician would make decisions in cases of fluctuating capacity. The regular review of capacity is important as it acknowledges that the individual may demonstrate decision-making capacity after a relatively short amount of time.

Considerations by those who were less supportive of the inclusion of capacity

- the introduction of a test of capacity could lead to risk, namely the possibility that someone might meet a test of capacity but be a risk to themselves or others;
- because the Act can only be used in acute situations it would therefore be rare for capacity to be present at these times;
- caution is needed as inclusion of decision-making capacity as a legislative requirement may result in superficial and administratively burdensome processes centred on the avoidance of risk; and,
- there are potential problems with the definitions surrounding capacity. This was especially raised in non-acute situations (such as eating disorders) when an individual has decision-making capacity but chooses not to engage in treatment. In these situations, the introduction of capacity would result in an inability for clinicians to make treatment compulsory.

Tests of decision-making capacity – issues to be resolved

Despite some support for the introduction of a test of decision-making capacity there was uncertainty:

- about how capacity assessment might be operationalised. Specifically, how a capacity test would work, what the requirements would be and who could assess capacity in a way that would effectively contribute to the safety and treatment outcomes of tāngata whaiora;
- surrounding situations of acute presentations in emergency departments and the difficulty of incorporating the holistic perspectives of others at such times;
- about how important environmental or situational contexts within which capacity is assessed will be considered and taken into account; and,

- given that disabled people are at particular risk of having capacity inappropriately assessed.

Who should assess whether a person has decision-making capacity?

Stakeholders generally agreed that capacity should not be solely determined by a clinician. Rather, capacity should be determined through a holistic process that centres on the individual's capacity and draws on the perspectives of cultural advisors, cultural practitioners, kaimahi, clinicians, tohunga, legal experts, significant others, and independent peer advocates who can support holistic decision-making around the needs of tāngata whaiora.

SUPPORTED DECISION-MAKING

We heard a high degree of support for:

- supported decision-making to be a legislative requirement; and,
- the use of advance directives, as a mechanism of supported decision-making, to be embedded in the legislation.

A number of requirements were suggested in relation to the operationalisation of supported decision-making in legislation. Most significantly we heard that there would need to be options for the collective involvement of a range of key people in the decision-making processes: clinicians, family, whānau, significant others, community leaders, peer support workers, cultural advisers, independent peer advocates.

We heard that supports and processes, including independent whānau support, are required to facilitate the involvement of family, whānau and significant others and to ensure that they are appropriately communicated with and have access to full information necessary for informed decisions to be made.

In navigating the tension between the rights of tāngata whaiora and the needs of family and whānau, we heard that in situations where family and whānau have been excluded, provision should be made whereby clinical staff revisit the question of family and whānau engagement and involvement, while respecting the right of tāngata whaiora to reject such opportunities. We heard that such opportunities need to be revisited at regular intervals.

Similarly, an array of different requirements necessary to support advance directives were offered. Most significantly, there is a need for:

- the prioritisation of the development of a national system for storage of, and ease of access to, advance directives;
- appropriate processes, support and resources to support the effective implementation of advance directives as a legislative requirement;

- advance directives to be dated and regularly reviewed to ensure they are up to date, as the needs and wishes of tāngata whaiora can change over time;
- the individual's wishes, as set out in an advance directive, to be safeguarded.

RESTRICTIVE PRACTICES

We heard that Aotearoa New Zealand's current focus is on crisis intervention and that the use of restrictive practices would greatly reduce with an increased focus on community-based comprehensive and preventative health care, including mental health.

Stakeholders had divergent views over whether restrictive practices should be allowed:

- lived experience, Māori health sector consultation participants and family and whānau shared that the use of restrictive practices are almost always unnecessary in inpatient settings;
- mental health sector consultation hui unanimously suggested that restraint and seclusion are necessary in some situations and the elimination of seclusion and restraints would prevent clinicians from keeping the individual, other tāngata whaiora and staff safe. In this regard, we heard the potential use of restraint as an option needs to exist in legislation;
- the majority of written submissions considered that some form of restrictive practice should be allowed (including some, and mostly tāngata whaiora, that referred specifically to allowing seclusion), but with many, including tāngata whaiora and whānau, stating the need for limits to be prescribed around use; and,
- notably a small number of written submissions indicated that no restrictive practices should be allowed. Of interest, approximately half of the submissions from kaupapa Māori, government and mental health professional bodies that commented on the use of restrictive practices, submitted that the practice of seclusion should be banned.

The elimination of seclusion was strongly proposed by consultation hui participants.

Mental health legislation and restrictive practices

In the main, stakeholders agreed the legislation should address the following areas.

Definitions

- There needs to be clear definitions of seclusion (and use of other restrictive practices). It was felt that vague definitions have enabled seclusion to be used in a way that is inconsistent with clinical or practice definitions of what seclusion entails.

Limitations

- Circumstances allowing the use of restrictive practices need to be tightly prescribed;

- Restrictive practices should only be used as a last resort and when all other appropriate options have been exhausted;
- “Last resort” should be clearly defined in mental health legislation;
- The use of restrictive practices should be time limited. They should only be used in situations of immediate danger, harm, and violence;
- Individuals should be free from restraint as soon as they are no longer actively attempting to hurt themselves or others; and,
- Decisions around seclusion, restraint and sedation should be informed by an individual’s advance directive.

Reducing restrictive practices

Across stakeholders we heard that the need for restrictive practices would be greatly reduced through:

- the incorporation of practices reflective of mātauranga Māori whereby the mana of tāngata whaiora are central to service provision;
- person-centred practices prevent the escalation of emotions, tensions and situations that lead to the point of intervening with seclusion or restraints;
- ensuring acute inpatient environments are designed to facilitate the individual’s healing;
- adequately resourced workforce, appropriate staff training and development.

Exclusions

- there was strong support from consultation hui stakeholders, and some submitter stakeholders (kaupapa Māori, government, and mental health professional bodies) for new legislation to eliminate seclusion;
- if legislation does ban seclusion, it also needs to expressly prohibit the use of chemical sedation as stakeholders were concerned that chemical sedation would be relied on as a substituted response; and,
- restrictive practices should not be used on children, young people, disabled people, and those who are suicidal.

Workforce standards

- legislation should require all staff to be trained in de-escalation skills, effective engagement practices, and trauma-informed practice as well as being supported to use these skills. Only those with such competencies should be permitted to use restrictive practices;
- organisations should ensure staff have a shared understanding about the use of restrictive practices and the consistent use of risk assessment tools
- there must be clear and consistent requirements and guidance defining the use of restrictive practices; and,

- legislation should require staff to undertake cultural competency training, including training to support an understanding cultural safety and the elimination of racism.

Monitoring and review

We heard that legislation should:

- embed safeguards where onus is placed on mental health professionals to demonstrate the need for the use of the restrictive practice;
- require mental health professionals to evidence that efforts to de-escalate have been attempted before seclusion or restraint can be exercised;
- protect tāngata whaiora by requiring the reporting of restrictive practices to an independent review body. Such reporting should include -
- the use and type of restrictive practice used;
- duration of the restrictive practice; and,
- clinical justification for the use of restrictive practice;
- require any restrictive practice event to be reviewed “quickly” and that such reviews should involve independent peer support advocates and family, whānau or significant others as part of the review process; and,
- require extensive internal and independent review practices as a legislative requirement.

PROTECTING AND MONITORING PEOPLE’S RIGHTS

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

A diverse range of different responses were offered. The most common response was that it should be a judge or the court who should be responsible.

Notably however, some consultation hui participants stated that the environment of current Mental Health Act courts is not conducive to a sense of wellbeing, especially for tāngata whaiora. As such, there was a call for a more informal process and potential environments like marae or community environments.

The process for approving the use of compulsory mental health treatment

There was strong support for a process that relied on a human rights framework and acknowledged the need to appropriately reflect te ao Māori worldviews. In particular a collective notion of self needs to be included in the approval process to reflect family and whānau as an essential component of engagement, decision-making, advocacy and support.

Supports to make it easier to engage in the process

The following suggestions were shared to ensure tāngata whaiora can be better supported to engage in processes to approve compulsory mental health treatment:

- ensuring tāngata whaiora and significant others are informed and understand key information including their rights and the processes under the legislation;
- including cultural, independent peer support and advocacy;
- including whānau need to be included in the decisions about compulsion, care, treatment and support of tāngata whaiora;
- ensuring workforce and accountability surrounding cultural competency as a prerequisite for working with Māori.

Onus on clinicians to demonstrate the rights of tāngata whaiora are upheld

The onus should be placed on those invoking mental health legislation to demonstrate the individual's rights are being upheld. This protection should be included in new mental health legislation.

Challenging clinical decisions

We heard tāngata whaiora need to be supported in their right to disagree and appeal clinical decisions and must have the right to:

- choose and refuse treatment, revoke consent, make their own choices;
- legal advice and representation;
- advocacy and support;
- have all alternative treatment options explored, with support from their clinician;
- independent review, monitoring and investigation;
- have their requests for alternative treatment options monitored, independently reviewed, and with proactive intervention when the individual's rights and wellbeing are compromised; and,
- seek recourse from an independent body, such as a court, tribunal or independent monitoring body.

An independent body to investigate complaints, monitor and review practice

We heard a great deal of support for the creation of independence surrounding the review of complaints and independent monitoring.

We heard strongly of the need for an independent complaints body.

We heard there is a need to for an independent monitoring body to:

- ensure greater oversight over treatment decisions, processes, services (as experienced by tāngata whaiora) and the effectiveness of the individual's treatment;
- independently monitor the use of compulsory treatment and restrictive practices including psychological, cultural, lived experience and whānau perspectives; and,

- monitor treatment options to ensure these are culturally appropriate, mana enhancing and include appropriate cultural involvement, including cultural advocates, kaumātua, has occurred in assessment and reviews.

We heard that such independent body/ bodies should have the following powers and responsibilities:

- constant and proactive monitoring, empowered to make unannounced visits to mental health care facilities;
- inspect, investigate, reach findings;
- require substantive actions to address findings;
- review and overturn, discharge a compulsory order; and,
- hold clinicians and mental health treatment facilities to account by issuing penalties and sanctions.

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INTRODUCTION

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) sets out the specific circumstances in which people may be subject to compulsory mental health assessment and treatment.

The Government Inquiry into Mental Health and Addiction, *He Ara Oranga*: *Report of the Government Inquiry into Mental Health and Addiction* (*He Ara Oranga*) recommended that the Mental Health Act be repealed and replaced 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' (recommendation 34). This recommendation was accepted by the Government in 2019.

Repeal and replacement of the Mental Health Act

Since 2019, the Ministry of Health has been developing immediate and short-term improvements under the current legislation, alongside work to understand what issues need to be addressed in creating new mental health legislation for Aotearoa New Zealand. These activities are reflected in the three work streams below.

Improving service user experiences under the current Mental Health Act:

- Published new Guidelines in September 2020 to promote the protection of the rights of people receiving compulsory mental health treatment and provide guidance on how the Act can be administered in line with Te Tiriti o Waitangi (Te Tiriti) and human rights principles
- Education and training underway to assist with changing practice in a way that will support future legislation.

Initial amendments to the current Mental Health Act:

- The Mental Health (Compulsory Assessment and Treatment) Amendment Act 2021 passed in October 2021 and aimed to better protect people's rights and improve safety. This Amendment Act addressed pressing issues, including the removal of indefinite treatment orders.

The full repeal and replacement of the Mental Health Act:

- Principles to guide development of new legislation approved by Government in 2019
- Review of previous related consultations, academic research, and international examples to understand key issues and potential options for new legislation
- Public consultation from 22 October 2021 to 28 January 2022 to inform new legislation.

This report provides the findings of the public consultation process arising out of the repeal and replacement workstream.

Public consultation

From 22 October 2021 to 28 January 2022 the Ministry of Health undertook a public consultation process to inform the development of new mental health legislation.

The aim of the public consultation was to seek feedback on key topics that must be addressed in the development of new legislation. A diverse range of perspectives were sought from the public and the mental health and addiction communities. Within this process the voices of those with lived experience, Māori and other key stakeholders were prioritised, having been informed by a combination of a commitment to Te Tiriti, and human- and disability-rights frameworks.

A discussion document, *Transforming our Mental Health Law*, was developed to support public consultation. The discussion document provided background information about the current legislation, reasons for repealing and replacing, and the vision for future legislation. It focused on the following seven key areas the Ministry hoped to receive feedback on as a means of guiding the development of policy proposals for new legislation:

- Embedding Te Tiriti and addressing Māori cultural needs;
- Defining the purpose of mental health legislation;
- Capacity and decision-making;
- Supporting people to make decisions about their care and treatment;
- The use of seclusion, restraint, and other restrictive practices;
- Addressing the needs of specific populations; and,
- Protecting and monitoring people's rights.

The public consultation involved two channels.

1. Written submissions.
2. Targeted consultation hui, including people with lived experience , Māori, Pasifika, and communities of interest.

A discussion of the analytical approach and participants is provided in the following section (Methodology).

The report is structured according to the general questions that guided the public consultation process. Sections 3 and 4, Contextual Issues and the Wider System and Operational Matters have been included despite the public consultation focus on policy related issues that might inform new mental health legislation. The Contextual Issues section is included to reflect the importance participants gave to a wide variety of issues that underscore the need for the repeal and replacement of the Mental Health Act. This section also highlights issues that need to be avoided in the development of new legislation.

The Wider System and Operational Matters section has been included as to reflect a range of operational, rather than legislative, issues that arose out of the public consultation process.

In addition to the main body of the report, the analysis of four targeted population groups who participated in the consultation hui have been included: those with lived experience, family and whānau of people with lived experience, Māori workforce, and the general mental health workforce. These targeted engagements have been analysed separately in acknowledgement of the need to avoid the risk of people's voices being potentially lost in the reporting process (see Appendices 1 - 4).

METHODOLOGY

The Ministry undertook an extensive consultation process and invited feedback through both written submissions and online information and consultation hui.

Written submissions

The Ministry of Health received 317 written submissions, of those:

- 155 specifically responding to questions through the online consultation hub on the Ministry of Health website; and,
- 162 submissions from individuals and organisations received by email (see Appendix 5 for a list of contributing organisations).

The majority of submissions were from tāngata whaiora (n=96) and family and whānau members of individuals with lived experience (n=58). Table 2.1 presents the number of submissions by stakeholder type.

Table 2.1: Submission by stakeholder type

Number by submitter type	**n=**	**%**
Individual		
Tāngata whaiora	96	30%
Whānau/family member of tāngata whaiora/person with lived experience	58	18%
Individual (no lived experience)	4	1%
Person who works in services that provide assessment/treatment under the Mental Health Act	29	9%
Person who works in other health or social services	13	4%
Person who works in a kaupapa Māori organisation	6	2%
Academic or researcher	5	2%
Other	8	3%
Subtotal	219	69%
Organisation		
Academic	3	1%
Government agency	5	2%

Mental health professional body (specific to mental health)	22	7%
Professional body in other health or social services	11	3%
Kaupapa Māori body	10	3%
Other	20	6%
Subtotal	70	22%
Not stated / rather not say	27	9%
Total	**317**	**100%**

As outlined in Table 2.2, the majority of the individual submitters identified as New Zealand European (n=107). The next most common ethnicity was New Zealand European/Māori (n=15) and Māori (n=14). We note that 29 percent of submitters did not state ethnicity (n=64)

Table 2.2: Submitters Self-Identified Ethnicity, Individual Submissions[1]

Number by Ethnicity (excludes organisation submissions)	**n=**	**%**
New Zealand European	107	49%
NZ European / Māori	15	7%
Māori	14	6%
NZ European / Samoan	2	1%
NZ European / Cook Island Māori	1	0%
NZ European / Fijian	1	0%
Indian	2	1%
Chinese	2	1%
Korean	2	1%

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[1] *This includes individual within the Other category. No ethnicity is reported for organisation submitters*

Asian	1	0%
Other	8	4%
Not stated ethnicity	64	29%
Total	**219**	**100%**

Responses to each of the submission questions were added to a database, to enable analysis, and to identify key themes and if there was commonality or divergence between stakeholder groups.

It was common for submitters not to answer all of the 69 consultation questions or for there to be a range of very minimal to lengthy answers. Consultation hub responses were predominantly from tāngata whaiora and whānau – the largest combined submitter group – and often responses were brief. Overall, this may reflect that not all of the questions were relevant to people's knowledge, experiences, or specific areas of interest. Also, because of the free-form nature of many of the non-consultation hub written submissions, many submitters only responded to particular questions, themes, or areas of interest, rather than all consultation questions. Commentary was also wide-ranging and diverse across questions areas.

In the absence of consensus, and when a small number of submissions answered a question, or responses have been wide-ranging, this document reports on the key themes to illustrate feedback. Where a majority of submitters indicated a shared or alternative view, this is stipulated.

Consultation hui

The Ministry of Health developed the approach and format of the consultation hui in collaboration with tāngata whaiora, including both Māori and tauiwi.

Over 500 people attended approximately 60 online consultation information and hui sessions which, on average, lasted two hours. Due to COVID-19 all sessions were held online via Zoom. The following groups participated in the consultation hui:

- general sessions open to any member of the public;
- wider mental health and addiction sector representatives, including additional targeted groups (for example Duly Authorised Officers, Nurses, Clinical Leaders, Directors of Area Mental Health Services, and District Inspectors);
- those with lived experience (for example people with lived experience of mental health and addiction, people with lived experience of restrictive practices, people with disabilities, young people);
- family, whānau and significant others of people with lived experience;
- Māori (for example, whānau, hapū and Iwi, and tāngata whaiora and people that work in the health and government sectors);

- Pacific communities (for example, tagata ola, aiga and clinical staff);
- Asian lived experience and mental health professionals; and,
- targeted population groups (for example, ethnic communities and Ara Poutama).

In addition, in an effort to provide widespread access, the Ministry also provided support for community organisations to be able to host their own submission sessions. The use of a range of channels including video and voice submission was offered with approximately 10 providing this option.

Each of the consultation hui were transcribed and analysed according to inductive thematic analysis.

Centrality of people's voice

Quotes from stakeholders have been included to illustrate key themes that have been raised and have been included verbatim. Where the quotes are from written submissions this has been indicated. A significant proportion of feedback was received orally through consultation hui, and these quotes have also been included verbatim.

Validation

The written submissions and the consultation hui were analysed separately. While there was divergence of viewpoints within people's responses, where clear positions were taken there was a high degree of consistency across the themes arising from the two consultation processes. Such consistency has provided a high degree of validation in the analysis and the interweaving of the two processes within the document.

CONTEXTUAL ISSUES

While the aim of the consultation was to elicit perspectives on the repeal and replacement of the Mental Health Act, the majority of submissions and comments from the consultation hui raised issues, concerns and suggestions that provide contextual information underpinning why stakeholders consider the repeal and replacement of the Act is important. Not all these issues are able to be addressed through legislation, however, these perspectives provide context for the repeal and replacement of the Mental Health Act and to provide foundational insights to inform the development of any legislation.

Misuse of the Mental Health Act

Through the feedback received, we heard that the Act has been misused in the following ways:

- as a punitive measure and to force an individual to receive treatment. Both facets were described as resulting in trauma and this was especially noted for disabled people;
- the Act is sufficiently ambiguous to result in varied and inconsistent application;
- people are being brought or are staying under the Act to access treatment and services that would not otherwise be available; and,
- accounts were offered of how hard it can be, or how long it can take, to come under the Act, with consequences such as near death and shattered lives.

Environment

Stakeholders considered that acute inpatient environments can exacerbate someone's distress and mental health legislation should require inpatient settings to be designed to reflect therapeutic and supportive environments.

Paradigm shift is required

An overarching view was that a paradigm shift is required to shift from an acute and crisis response to a focus on prevention, and the provision of early engagement with comprehensive services. It was considered that such a paradigmatic shift would:

- reduce the risk of escalating mental distress that might result in the individual coming under the Act;
- require a shift in focus away from the singular privileging of psychiatry;
- require increased resourcing and address current levels of gross under-resourcing;
- require a shift in focus from detention to holistic and person-centred treatment and in- and out-of-inpatient services so the individual can return home sooner. Within this context we also heard that the provision of ongoing support is essential; and,
- regard compulsory treatment as a last resort and that other alternatives to the Act should be tried first.

Tino rangatiratanga, kāwanatanga and partnership

Concern was raised that the current crisis in mental health responsiveness has coincided with an erosion of kaupapa Māori services working in mental health and addiction settings.

Across stakeholders, two primary perspectives were identified:

- the first cohort spoke strongly about the need to embed Te Tiriti within new mental health legislation. This cohort, from written submissions and consultation hui, stressed that Te Tiriti embedded legislation establishes a requirement for legislation, related policy and practice, to be co-developed and written in partnership with mana whenua; inclusive of tāngata whaiora.
- the second cohort stressed that the wellbeing of tāngata whaiora and their whānau can only be achieved by devolving service provision to Iwi, hapū, Māori community-based service providers and kaupapa Māori services.

The centrality of family, whānau and significant others

Across stakeholders, family and whānau were described as essential to the wellbeing of tāngata whaiora with the need to acknowledge family, whānau and significant others as a central component of the distressed individual's wellbeing. Within this context it is important to give paramountcy to the wishes of tāngata whaiora about the inclusion of family or whānau, and to protect the tāngata whaiora.

We heard from across all stakeholders that there is a need for the Mental Health Act to be made more relevant and to be more tāngata whaiora and whānau focused.

Experiences of compromised and negated autonomy, choice, and participation in decision-making were shared. We also heard that mental health legislation should be underpinned by a person-centred approach whereby tāngata whaiora, family and whānau are afforded respect and dignity.

> *I have felt dehumanized in the face of my mental health and that's a feeling I wish on no one. (Written submission, Tāngata whaiora)*

We heard that Te Tiriti must be at the foundation of mental health legislation. We heard that mental health legislation needs be more empowering; providing tāngata whaiora with protections under a human rights framework. We also heard a strong call for rights to be upheld in alignment with international conventions, with frequent reference made to the Convention on the Rights of Persons with Disabilities (UNCRPD) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) .

Misuse of the Mental Health Act

We heard that the Mental Health Act has been misused. Participants shared that, rather than appropriately engaging with tāngata whaiora, the Act has been used coercively to force the individual to receive treatment. We also heard that tāngata whaiora and whānau often do not understand the Act or the criteria that sits within the Act. This lack of understanding makes it easier for tāngata whaiora to be coerced into accepting mental health treatment they might not want.

We heard that the Mental Health Act is sufficiently ambiguous to result in differing interpretations and varied and inconsistent application and, as a consequence, it was reported that the is Act being applied differently by DHBs and stakeholders. As a result, we heard that new mental health legislation needs to ensure consistent application.

We heard that the Act has been used as a punitive measure, often to control and punish tāngata whaiora who are not deemed compliant or appropriately responsive to health professionals.

> *It feels like playing a game but the game is rigged against us…You have to agree with everything or you'll never get out. (Written submission, Tāngata whaiora)*

We heard many accounts of people being traumatised whilst under the Mental Health Act. Descriptions included terms such as "torture", "hostile" and "culturally unsafe" were common. We also heard of loved ones who had died as a result of how the mental health system treated the individual.

At the same time, there are those who offered accounts of how hard it can be, or how long it can take, to come under the Act, with consequences such as near death and shattered lives.

Included in this are the experiences of those who have not been immediately recognised as needing mental health treatment due to the comorbidity of mental distress and substance abuse.

It is also widely understood that some people are being brought or are staying under the Act to access treatment and services that would not otherwise be available.

While traumatic experiences were commonly shared, we also heard about traumatic experiences specific to those living with a disability. We heard that many disabled tāngata whaiora believe providers lack an understanding of their needs and this has resulted in disabled people's means of communication and mobility having been removed.

We also heard of no accommodations being made for disabled people. This was particularly raised for neurodiverse populations. Participants shared disabled people's experiences of inappropriate inpatient facilities including the trauma of restrictive practices exercised without regard for or understanding of the individual.

Unfamiliar environments or people, forced social interactions, the noise and light of clinical settings can be highly distressing to autistic people. It is not hard to imagine seclusion, restraint of compulsory treatment keeping an autistic person stuck in a state of distress in which they seem, or are, without capacity. (Written submission, Tāngata whaiora)

Environment

We heard from family and whānau that acute inpatient environments can exacerbate someone's distress. It was considered that mental health legislation should require inpatient settings to be designed to reflect therapeutic and supportive environments.

Across stakeholders we heard that acute mental health settings often feel so unsafe that tāngata whaiora ask to be placed in seclusion, despite seclusion being an agonising experience for them. We heard that there is a need to change clinical culture and environments to ensure that people feel safe.

It was felt that core principles of care, kindness, not being judged, respect, dignity, empathy, compassion, being client-centred, listened-to, receiving manaaki and warmth have been notably absent from inpatient care experiences.

A paradigm shift is required

Across stakeholders we heard of the need for a shift in paradigm from a reliance on western biomedical approaches to a focus on prevention, and the provision of early engagement with comprehensive services. Stakeholders suggested that such a shift would result in a reduction in mental distress and therefore a decrease in the risk of an individual coming under the Act.

Stakeholders asserted that many parts of the social, justice and health systems are siloed and, as a consequence, tāngata whaiora and whānau face insurmountable barriers engaging in preventative support and early intervention. As a consequence, the current mental health system was described as having developed a focus on crisis intervention rather than prevention and early intervention.

Linked to the predominant crisis intervention focus, we heard that the current approach to acute mental health is risk aversion and such clinical attitudes act as a barrier to the mental health workforce listening to the needs and wishes of tāngata whaiora and providing requisite treatment and support. We further heard that the "woeful state of the mental health system" may leave some clinicians little choice but to place someone under the Mental Health Act, or at the other extreme, make it extremely hard for treatment to be accessed.

From consultation hui and written submissions, we heard that new mental health legislation should reflect a shift in focus away from detention and compulsory treatment's reliance on dominant western biomedical models which has resulted in the singular privileging of psychiatry.

Submissions referred to the over-emphasis on medication to the exclusion of an equivalent focus on and access to therapies, and the harm and side-effects caused by ongoing, long-term use of medication. We heard that medication is being used to sedate and stop symptoms rather than being used for the purposes of treatment and healing.

Across stakeholders we heard that legislation needs to focus on holistic and person-centred treatment and in- and out-of-inpatient services so the individual can return home sooner. Within this context stakeholders asserted that the provision of ongoing support is essential.

Both consultation hui and written submitters stressed there should be a greater focus supporting people in their homes and in the community and that this should be directed under any new legislation as this may assist in people recovering faster in their own environment with family support.

From consultation hui it was suggested that a shift to a holistic and person-centred paradigm might be achieved by incorporating an independent person to facilitate the Mental Health Act process or using an Approved Social Worker model similar to that operating in the United Kingdom. The incorporation of a similar approach would reduce the enactment of compulsory orders in lieu of alternative treatment and support pathways.

We heard that the Mental Health Act should be used as a last resort only and that other alternatives to the Act should be tried first. Further, we heard that such efforts need to be documented and the need for such documentation should be embedded in legislation.

For those envisioning mental health legislation that excludes compulsory treatment, there needs to be corresponding and significant paradigmatic and practice shifts to otherwise meet care, treatment and support needs.

> *The mental health system in Aotearoa is fundamentally broken. People are on wait lists for months before being seen. Suicide rates are appalling and can be due to suicidal people not being seen in a timely manner. Our homeless people have high rates of mental health problems and few avenues open to them if they do not choose to be in state housing. The entire system needs to be fixed if we are to adequately address the needs of those in extreme mental distress. The ideal would be not to have to section anyone, but to offer them help in their comfort zone. Unfortunately, the system as it is cannot adequately help those it already needs to look after, and removing the mentally distressed from wards and forced mental care will add more strain to an already groaning system. To help the sickest, we must fix the entire structure. (Written submission, Tāngata whaiora)*

Both consultation hui and written submitters stressed that, integral to a shift in paradigm, is the need for sufficient resourcing and coordination to enable tāngata whaiora and their whānau receive comprehensive services. Submissions described the current system as fraught with gross under-resourcing, insufficient staffing, delays in access and an acute shortage of mental health support services and therapies in community settings, as well as significant wait times to see mental health professionals. We heard that transformation is not possible without such issues being addressed.

Tino rangatiratanga, kāwanatanga and partnership

Across stakeholders, both consultation hui and submissions, acknowledgement and concern was raised about the disproportional representation of Māori under the Mental Health Act. Stakeholders consider that this has occurred because of racism, discrimination, cultural bias, and a lack of understanding of Māori culture. We heard repeated concern, including from some clinicians, about the inherent biases of mental health professionals that have disproportionately disadvantaged Māori through the use of the Mental Health Act. We heard racism and discrimination can manifest in a disproportionate readiness to place Māori under the Mental Health Act and Māori being placed under the Act for longer periods of time than non-Māori.

From consultation hui with the Māori mental health sector we heard that tāngata whaiora Māori and their whānau have been better served throughout the 1970's and 1980's. We heard that there are considerable lessons from this development; specifically the cultural alignment and integration of te ao Māori practice within mental health systems.

We heard, for example, of the impact of the inquiry in mental health services in the mid-1990s (the 1996 Mason Report) which resulted in the establishment of the Mental Health Commission. The Commission was especially noted as driving a reduction in discrimination against those with mental illness.

We heard that the current crisis in mental health responsiveness has coincided with an erosion of kaupapa Māori services working in mental health and addiction settings. We have also seen a reduction in whānau support workers. Across stakeholders, including the consultation hui and written submissions, two primary perspectives were identified. The first spoke strongly about the need to embed Te Tiriti within new mental health legislation. This cohort stressed that Tiriti embedded legislation establishes a requirement for legislation, related policy and practice, to be co-developed and written in partnership with mana whenua; inclusive of tāngata whaiora.

The second cohort stressed that the wellbeing of tāngata whaiora and their whānau can only be achieved by devolving service provision to Iwi, hapū, Māori community-based service providers and kaupapa Māori services.

The centrality of family, whānau and significant others

Views shared by family and whānau expressed a high level of anger and frustration about the Mental Health Act, the mental health system and the failure of the system to recognise the importance of family and whānau as a central component of the distressed individual's wellbeing.

We heard that family and whānau are essential to the wellbeing of tāngata whaiora. We heard that whānau hold significant knowledge and understanding of the experiences and needs of tāngata whaiora.

We also heard that definitions of family and whānau should include significant others, as defined by tāngata whaiora. The inclusion of significant others acknowledges people with no biological relationship to tāngata whaiora.

We also heard that young people and children need to be included in the definition of family and whānau. Such inclusion acknowledges that young people and children, and not exclusively adults, can provide support.

We also heard that mental health legislation should acknowledge that the wishes of tāngata whaiora about the inclusion of family or whānau should be paramount. This was considered important because it cannot be assumed that all tāngata whaiora have a positive or supported relationship with their family or whānau.

We heard that many family and whānau believe that the Mental Health Act has effectively protected clinicians. From family and whānau we heard that mental health legislation should aim to protect tāngata whaiora.

WIDER SYSTEM AND OPERATIONAL MATTERS

Participants commonly raised issues and made recommendations that addressed operational rather than legislative considerations. Many of these are considered essential to facilitate necessary legislative and wider system transformational change. The issues and recommendations are presented here to inform the ongoing work to transform the mental health and addiction system, including the development of the Mental Health and Addiction System and Service Framework. Commonly raised feedback encompassed the need to:

- improve support for family, whānau and significant others;
- develop and increase the peer and cultural support workforce;
- invest in workforce leadership, development, and training;
- grow the Māori mental health workforce, and the workforce in general to meet need;
- address racist and discriminatory practice;
- establish effective monitoring and accountability;
- establish effective debriefing processes for post-compulsory treatment planning and care; and,
- significantly improve care and treatment environments.

Parallel to the repeal and replacement of the Mental Health Act consultation process, the Ministry of Health has a broad programme of work underway to transform Aotearoa New Zealand's mental health and addiction system. This includes the development of the Mental Health and Addiction System and Service Framework to respond to operational issues identified by *He Ara Oranga*.

The framework will set expectations for what services will be available to individuals, whānau and families; how services should be organised locally, regionally, and nationally; and the critical shifts required to get there within a 10-year horizon. The aim of the framework is to capture the sector's aspirations and provide a clear direction of travel for the sector and services in the future. It is anticipated that the framework will be used by Government, the Ministry of Health, the two new health entities and all service providers to guide policy development, accountability frameworks, investment decisions, commissioning of services and service delivery, innovation, and improvement. The Ministry is working closely with interim Health New Zealand and interim Māori Health Authority sharing a commitment to its implementation.

Both consultation hui and written submissions identified that new legislation should be guided by the system transformation approach outlined in *He Ara Oranga*.

Within this context, stakeholders stated that it is not sufficient to solely focus on legislative change. Rather, a number of recommendations were made for changes to the mental health system that would significantly result in reduced rates of compulsion. Feedback pointed to the need to shift to person-centred, holistic and healing approaches and environments and that legislative change needs to be guided by a commitment to resource workforce development, funding models and configuration of services. It was put forward that these recommendations need to be clearly stated in any new mental health legislation. We also heard that such clarity would remove confusion and support the provision of required services.

A paradigm shift (operational considerations)

Stakeholders supported a paradigm shift to person-centred approaches that is accompanied by a mana enhancing culture, safe and appropriately designed facilities, and adequate staff ratios. Further, in alignment with mana enhancement, staff need to be trained, and engage in, de-escalation practices. As proposed in the written submission of a mental health professional body:

> *Legally mandate, where possible, service development and practice changes, including upholding mana-enhancing care as a guiding principle in the new law to protect and enhance tāngata whai ora mana and dignity. (Written submission, Mental health professional body)*

We heard that assessment and service provision needs to view tāngata whaiora holistically and thereby remove classifications, arising out of competitive funding models, that result in siloed and disparate service delivery (for example the individual having to access different service providers for diabetes and mental health). We heard that removal of artificial classifications would significantly contribute to the delivery of seamless care and wrap-around support across services, systems and the sector in general.

Some stakeholders referenced recommendation 35 of *He Ara Oranga*, supporting the need for a coordinated national conversation between tāngata whaiora, whānau, agencies and professionals to reconsider beliefs, evidence and attitudes about mental health and decision-making. We heard that this should be implemented in tandem with the enactment of new mental health legislation.

Holistic worldview: The inclusion of peer and cultural support

We heard that family, whānau and significant others need assistance to enable them to support tāngata whaiora. We heard that such support is essential to reducing incidents of compulsory treatment, as families adequately trained and supported can address issues as they arise. In this context, assistance given to family and whānau prevents escalation to an acute level.

There is a need for a greater peer support workforce to be fully accessible and available to tāngata whaiora.

There is a need for a holistic and person-centred focus on wellbeing and a responsive willingness to respond to the needs tāngata whaiora and their whānau. Similarly, stakeholders considered that there should be a requirement to offer tāngata whaiora appropriate choices of treatment, including culturally appropriate models of health.

There is a need for culturally appropriate assessment and that cultural needs are understood and integrated into all aspects of assessment, care treatment.

We heard that restrictive practices would be greatly reduced through the incorporation of cultural and peer support mechanisms, such as kaumatua.

Workforce

There is a need for sector leadership and workforce development to support implementation. This will require leadership to embrace person-centred and mana enhancing practice.

There is a need for a commitment to resource the implementation of new legislation in terms of workforce training, funding models and service provision.

The workforce needs significant training and development to facilitate paradigm shifts.

There is a need to enhance workforce capabilities addressing areas such as institutional racism, cultural safety, least restrictive practice options, obligations under UNCRPD, trauma-informed care and decision-making capacity assessment.

There is a need to identify workforce health professional support needs, which should be part of the principles and objectives of new mental health legislation.

An increased Māori mental health workforce is needed who have the ability to provide support in accordance with te ao Māori healing practices.

There is a need to grow the mental health workforce to ensure Māori cultural advisors and experts and Māori clinicians, peer support and independent lived experience advocates are available. Greater staff ratios are required overall.

We heard one measure of a successful Treaty partnership would be equitable provision of Māori staff and Māori managers within the health and mental health care system.

Staff need to be trained in how to provide care to those living with a disability, inclusive of neurodiversity.

All clinical staff need to be trained to provide culturally safe and competent care to tāngata whaiora Māori .

We heard that there is a need for the System and Service Framework to address racist and discriminatory practices amongst staff, including monitoring of services.

We heard mental health legislation should be accompanied with workforce development, monitoring and accountability.

It is not sufficient to solely focus on legislative change. Rather, there is a need to simultaneously address workforce development, funding models and service configuration.

Environments

Inpatient environments should be designed around the therapeutic and holistic needs of tāngata whaiora.

Appropriately designed inpatient environments – low sensory/stimulus, peaceful, restful, caring, and quiet environments and which incorporate nature - would greatly reduce the need for seclusion and restraint due to the elimination of environmental triggers.

There needs to be provision for wheelchair accessibility, and accommodation for the different needs of disabled people, including physical and sensory needs.

Tāngata whaiora, and especially Māori, need te ao Māori to be embedded in all mental health environments, especially acute care units. Environments need to be welcoming of and appropriate places for family and whānau to come.

Person-centred environments should reflect better acute mental health care settings with smaller number of tāngata whaiora and the provision for peer acute alternatives. Such settings were furthered as reducing stress and therefore reducing the potential need for the use of restrictive practices.

There is a need for greater use of, and focus on, community-based care and treatment.

There is a need for safe healing places in the community that tāngata whaiora can voluntarily access to seek respite. These therapeutic spaces should be easy to access, safe, culturally and age appropriate, and provide welcoming, hopeful, healing and restful environments.

Debriefing and follow up processes and transitional planning and care

There is a need for legislation to require organisations to engage in debriefing/follow up processes with tāngata whaiora who have experienced restrictive practices. The spirit underlying follow up would be to address possible trauma experienced by tāngata whaiora from the use of restrictive practices and to develop a strategy to avoid enlisting such practices in the future.

There is inadequate and variable continuity of care - transition planning and support from acute inpatient to community care, lack of comprehensive linkage and hand-over to community services, and lack of follow-up following discharge.

> *We heard stories from people who are isolated – both physically and socially – having to travel great distances to receive mental healthcare and being left to find their way*

> *home after being discharged with no transport, financial means, or connections to do so. (Written submission, Mental Health Professional Body)*

One written submission from a person providing services under the Act identified that there are multiple issues following transition to the community from an acute unit including plans not being completed by the discharge date, family and whānau not consulted in discharge planning, the transfer of care between inpatient and community clinicians not occurring, failures in relation to alert levels leading to relapses, community-based services not involved, and a lack of cultural advice and information to caregivers or guardians.

The way in which tāngata whaiora are supported to return to their community also needs to addressed, for example supporting tāngata whaiora Māori with appropriate tikanga as part of their return home, and involving a whakanoa process with staff.

Universal use of advance directives

In addition to mental health compulsion, we heard that people, in general, should be encouraged to develop advance directives.

SHOULD THERE BE COMPULSION?

Many stakeholders shared a desire for the removal of compulsory treatment from mental health legislation. Of these, most however, did not believe removal is possible at present due to the current design and focus of mental health services. In this sense, no compulsion was viewed as aspirational.

The majority of those participating in the consultation hui agreed that mental health legislation should include the limited use of compulsion, but that legislation should stress that compulsion is a last resort only.

Perspectives on whether or not there should be compulsion fell into two distinct cohorts. This section addresses the often-competing perspectives.

Those in favour of significant reductions or total removal of compulsion

Those who supported the removal of compulsion from legislation referenced the following systemic problems:

- the incompatibility of compulsion within a human rights framework, that non-consensual treatment and involuntary detention is a breach of UNCRPD and that new legislation continuing with this would be a serious breach of obligations;
- compulsion does not align with te ao Māori and Pacific worldviews;
- the way society, inclusive of clinicians, views mental distress, which can lead to misdiagnosis and use of the Act. This was especially noted for Māori;
- a reliance on dominant western biomedical psychiatric models has resulted in a singular privileging of psychiatry;
- there is a need to shift mental health legislation from a singular crisis intervention focus to ensure universal engagement, early intervention, treatment, recovery and holistic support of tāngata whaiora; and,
- that tāngata whaiora Māori and their whānau would be better supported by the equivalent choice of kaupapa Māori services and that service provision should be devolved to Iwi Māori and kaupapa Māori services.

Those who are cautious about or opposed to a complete removal of compulsion

We heard support for the inclusion of compulsory treatment in mental health legislation because of a concern that:

- the removal of compulsion may leave some people unwell, vulnerable, homeless, and unable to care for themselves, with the risk of inhumanely not treating an individual and possibly leading to increased suicidality and death.
- tāngata whaiora who are not aware of their need for treatment will remain untreated while simultaneously being a risk to themselves or others and decline in their health and wellbeing;

- without appropriate mental health legislation there is a risk of people entering the criminal justice system, as opposed to being assisted by the health system; and,
- a lack of compulsion could result in extra pressure being placed on families.

Areas of consensus

Despite the above differences, the two cohorts agreed:

- it is important to implement compulsory treatment orders without adversely affecting the individual;
- legislation should advance supported decision-making, particularly advance directives (in place of substituted decision-making) as a means of empowering tāngata whaiora and ensuring their rights and wishes are followed; and,
- some degree of compulsion might be required when someone has no previous mental health diagnosis and suddenly experiences an acute mental health crisis.

Many stakeholders shared a desire for the removal of compulsory treatment from mental health legislation. Of these, most however, did not believe removal is possible at present due to the current design and focus of mental health services. In this sense, no compulsion was viewed as aspirational.

The majority of those participating in the consultation hui agreed that mental health legislation should include the limited use of compulsion, but that mental health legislation should stress that compulsion is a last resort only. Notably, no consensus was communicated over how “last resort” might be defined. At best, last resort was used in reference to a broad range of situations, ranging from acute psychotic episodes to those with severe eating disorders.

It is noteworthy that while some people with lived experience acknowledged the need for compulsion, the majority generally supported the removal of compulsion from mental health legislation. We heard that compulsion is counter to human rights, results in retraumatising people who are already in distress and does not address the trauma underpinning most mental distress in order to promote healing and sustained recovery.

In terms of written submissions, approximately half did not state a specific position about whether or not compulsion should be allowed. As with consultation hui comments, for those that did state a particular position, the majority (across stakeholders) agreed with the potentiality of compulsion - either in situations of necessity and/or specifically defined circumstances. Over a half of these submissions expressly stated that compulsory treatment should only be allowed as a matter of last resort, where there was no other alternative, and in extreme circumstances.

The following analysis first describes the rationale underpinning those who are in favour of significant reductions, or the total removal, of compulsion. This is followed by a description of those are cautious about a complete removal of compulsion.

Those in favour of significant reductions or total removal of compulsion

Those who supported the removal of compulsion from legislation referenced the incompatibility of compulsion within a human rights framework.

One organisation submitted that non-consensual treatment and involuntary detention is a breach of UNCRPD and that new legislation continuing with this would be a serious breach of obligations. Moreover, for this stakeholder, concerns about ensuring appropriate care, support and treatment should not rely on compulsion, but rather on the system to ensure appropriate alternative care and support.

A small number of written submissions proposed a two-phased approach toward moving to remove compulsion due to the need for system change to support non-compulsion. This would involve a set timeframe to work towards, with the first phase incorporating more tightly restricted, last resort use of compulsion.

Tāngata whaiora Māori and whānau attending consultation hui considered that compulsion does not align with a te ao Māori worldview. It was emphasised that whānau Māori want access to kaupapa Māori services and supports that will enable them to get the right care, at the right time, for their tāngata whaiora whānau members.

Similarly, Pasifika with lived experience noted that compulsion is counter to Pacific worldviews and practice that rests on the influence of family to encourage and support the individual to access care. There was a belief that this means family should be provided greater supports to be able to support their tāngata ola.

Stakeholders related that no compulsion requires a shift in the way society, inclusive of clinicians, views mental distress, which they considered as contributing to misdiagnosis and use of the Act. This was especially noted for Māori.

Across stakeholders, there was a view that a reliance on dominant western biomedical psychiatric models has resulted in a singular privileging of psychiatry.

We heard that being placed under the Mental Health Act was the first time that some people were able to receive support and treatment, as barriers to service engagement had resulted in drastic elevation of their presenting issues. As such, stakeholders considered there is a need to move from a compulsory treatment focus to universal engagement, early intervention, treatment and holistic support of tāngata whaiora.

For Māori and Pasifika, we heard that universal support should include the whānau and family of tāngata whaiora. The need for wraparound services was also emphasised by those attending the Māori health sector hui: “We tend to wait until they fall off the cliff and then deal with it through compulsion”. It was identified that the provision of these services would assist people to access support early and greatly reduce the compulsory treatment embedded within the current legislation. Stakeholders noted that this would require a financial commitment from the government and that new legislation should provide this direction.

We heard that Mental Health Act should be broadened to ensure that legislation provides clinical support for all those who are living with a mental illness. Such provision would assist people access support earlier and greatly reduce the compulsory treatment embedded within the current legislation.

A number of consultation hui participants asserted that health care should be devolved to Iwi Māori and kaupapa Māori services. We heard tāngata whaiora Māori and their whānau would be better supported by kaupapa Māori services. We heard that such devolution should be embedded in new mental health legislation.

Stakeholders were of the view that supported decision-making should replace substituted decision-making and that supported decision-making is contingent upon:

- the appropriate implementation and widespread use of advance directives;
- adequate resourcing for mental health support, particularly peer and cultural support; and,
- advocacy provisions.

We heard there is a need to shift mental health legislation from a singular crisis intervention focus to prevention and early intervention.

Family and whānau shared accounts of their guilt and regret having endorsed decisions to place their loved ones under the Mental Health Act. We heard that they had provided their endorsement because of fear and a reliance on the perceived expertise of mental health professionals.

Those who are cautious about or opposed to a complete removal of compulsion

As previously discussed, many stakeholders shared a desire for the removal of compulsory treatment but did not believe removal is feasible within the current system and instead viewed no compulsion as aspirational.

We heard support for the inclusion of compulsory treatment in mental health legislation because of a concern over the wellbeing of tāngata whaiora. We heard that the removal of compulsion may leave some people unwell, vulnerable, homeless, unable to care for themselves, risk inhumanely not treating an individual and possibly lead to increased suicidality and death.

> *Yes it is hard when human rights come into play but when I was 17 I was majorly suicidal and if there was no compulsory mental health treatment then I wouldn't be here today. (Written submission, Tāngata whaiora)*

Particular concern was shared in the context of tāngata whaiora without awareness of the need for treatment, and including the harm caused by repeat acute occurrences for people with lifelong conditions.

Stories were shared of lives saved due to compulsory treatment, and also of lives wrecked or nearly lost due to the time delays and difficulties it took to come under the Act.

> *My family member lost her career, her husband, her home, her friends and family. She was homeless. It took losing everything before the courts deemed her unable to care for herself. People shouldn't have to hit rock bottom… the people with psychiatric disorders that need this act the most due to the nature of these disorders are unable to know they are unwell and therefore unable to make the best decisions. (Written submission, Family or whānau member)*

We also heard concern that those who are unwell, without appropriate mental health legislation risk entering the criminal justice system, as opposed to being assisted by the health system. Stories were shared of those who had ended up in prison because it took too long for them to be brought under the Act, or because they had been discharged too soon. Others instead framed a lack of compulsion having negative consequences for community members.

From some family and whānau we heard that their loved one was a significant risk to themselves and compulsory treatment was a necessary intervention. There was a real sense of fear from some whānau that removing the compulsory treatment would put their loved one at greater risk. This was especially noted in situations where the individual did not acknowledge that they were unwell or in need of treatment.

> *Without the compulsory treatment section of the Mental Health Act, I strongly believe that he would not be here today. On multiple occasions he has threatened to kill me and on some occasions I have had to run and hide or phone the police. (Written submission, Family or whānau member)*

The extra pressure on families that could arise from a lack of compulsion was a noted concern.

Areas of consensus

While the necessity of compulsory treatment orders was raised by consultation hui participants from the mental health sector and across written stakeholder submissions, we also heard that it is important to implement these orders without adversely affecting the individual.

We heard universal support for the greater use of advance directives as a means of ensuring the individual's wishes are followed.

Stakeholders raised that in the absence of advance directives there may be situations where some degree of compulsion might be required, namely when someone has no previous mental health diagnosis and suddenly experiences an acute mental health crisis.

IF THERE WAS SOME COMPULSION, WHAT WOULD IT LOOK LIKE?

When and where should compulsory treatment be allowed

Participants considered that compulsion should only be allowed as an option of last resort. This would mean that criteria for compulsory treatment under mental health legislation should reflect extreme and serious circumstances and where no other option exists. Participants offered suggested compulsory criteria and core principles to inform the new mental health legislation.

There was consensus that there should be a range of settings and options available to tāngata whaiora (and their whānau) that provide the most appropriate treatment support.

Which health professionals should be allowed to assess whether a person needs compulsory mental health treatment?

Participants identified a range of mental health and health professionals that should be allowed to assess the need for compulsory mental health treatment. There was no particular consensus on any one specific health professional. Commonly participants considered it was important that:

- assessment involve a group or multidisciplinary team approach (and should not be an individual decision); and,
- there is involvement of family, whānau and significant others in the assessment process.

We heard that those undertaking the assessment should be trained, culturally safe, and experienced and specialised in assessment, including crisis assessment.

Safeguards

Participants identified a range of checks and protections that they considered are required in any new mental health legislation.

Rights of tāngata whaiora

Stakeholders consider that legislation should explicitly state that:

- tāngata whaiora are entitled to the provision of full information to enable them to participate in decision-making processes, to make fully informed decisions, and to ensure informed consent. This includes the right to choose and refuse treatment based on full information, and to be fully informed about the process and what will happen, as well as the benefits and disadvantages of different decisions;
- tāngata whaiora Māori, whānau, hapū, and Iwi should be fully informed and empowered to participate in assessment processes and to be a part of decision-making; and,

- decisions surrounding intervention should align with an individual's wishes, as outlined in advance directives.

Monitoring and reviews

A number of recommendations were identified for monitoring and review, these included:

- treatment should be independently reviewed to ensure it adheres to best practice;
- family, whānau and significant others should be given the right to "audit" services;
- second opinions should be independent;
- there should be timely investigations of complaints or issues as they arise; and,
- clinicians needing to evidence their prescribed treatment in accordance with best practice.

Limitations

Stakeholders identified that legislation should explicitly time limit compulsion and require it to be of a shorter duration.

Tāngata whaiora always supported

Participants outlined that tāngata whaiora should always have:

- easy access to proactively offered peer and cultural support, including independent advocates;
- the right to access cultural and spiritual supports from the outset and across the spectrum of treatment (including kaumātua, tohunga, kaiawhina); and,
- automatic provision of cultural care and support.

Centrality of family, whānau and significant others

Participants spoke of the significance of family, whānau and significant others to the wellbeing of tāngata whaiora, it was identified that:

- whānau are essential to the wellbeing of tāngata whaiora;
- a holistic focus means that a collective notion of self needs to be included in mental health legislation to reflect whānau as an essential component of engagement, decision-making, advocacy and support;
- legislation should acknowledge that the wishes of tāngata whaiora about the inclusion of whānau should be paramount;
- legislation should explicitly allow for significant others, as defined by tāngata whaiora, to be part of the decision-making process;
- legislation should include provision to support the whānau;
- for tāngata whaiora Māori, whānau, hapū, and Iwi should be fully informed and empowered to participate in assessment processes and to be a part of decision-making.

Provision for culturally appropriate responses

A range of views were shared on how legislation could be more culturally appropriate:

- the inclusion of the perspectives of whānau and those with cultural expertise is necessary to ensure sufficient context is provided to contribute to appropriate decision-making;
- a model of care needs to be implemented that is founded upon respect, time taken to know the individual and understanding their life course (whakapapa) and needs;
- tāngata whaiora Māori should have the choice of western or Māori approaches and Māori healing practices; and,
- mental health needs to be understood and responded to from a te ao Māori perspective and within the context of Māori models of health.

Cultural assessment

Stakeholders emphasised the need for increased use of cultural assessments. Mental health legislation should:

- require the provision of such assessments and such provision should be linked to protection-related Treaty obligations;
- require cultural assessments to be considered in all decision-making, equitably against psychiatric assessments;
- specify a quality standard that cultural assessments need to attain;
- require cultural assessments to be holistic and include psychological, cultural, and spiritual considerations; and,
- include provision for increased resourcing to ensure cultural assessments are conducted to a high standard and undertaken by culturally competent practitioners.

Court engagement

Participants identified that judicial processes need to be person and whānau-centred and above all adhere to mana enhancing practices. Mental health legislation should make provision for such practices.

Mental health workforce

We heard that legislation should require:

- mental health providers to demonstrate cultural competency; and,
- tāngata whaiora Māori should have access to Māori practitioners skilled and knowledgeable in te ao Māori and te reo Māori to ensure cultural perspectives are brought to care, assessment, treatment, and support, and to ensure cultural appropriateness.

When should compulsory treatment be allowed?

From hui consultation participants, we heard that mental health legislation should stress that compulsion should only be allowed as a last resort option.

Just under a quarter of written submissions responded to questions about when compulsory treatment should be allowed:

- over a half of these submissions, from across stakeholders and including tāngata whaiora and whānau, specifically identified that criteria for compulsory treatment under mental health legislation should reflect extreme and serious circumstances and where no other option exists; and,
- a lesser number identified the criteria of danger and harm or risk of danger and harm but without attributing levels of severity to this, which may or may be purposeful. Such submissions were nearly all from tāngata whaiora and family and whānau.

For the submissions that suggested criteria relating to extreme and serious circumstances, the following were the different compulsory criteria mainly suggested across these submissions:

- every other option tried;
- the individual is experiencing extreme mental distress;
- the individual has demonstrated extreme harm or self-harm;
- there is serious risk that the individual will harm themself or others;
- actual or immediate (physical) harm has been caused to the individual or to others and serious harm will otherwise continue unless the individual is placed under compulsory treatment;
- the individual is significantly damaging their lives (including their career, relationships, and finances);
- the individual's behaviour is seriously affecting others;
- in the severest of cases;
- the individual is unable to care for themselves (self-neglect) and unable to manage or function;
- the individual will not get better without treatment, or will deteriorate and their health and wellbeing will be damaged;
- the individual is not accepting or unable to see that they are unwell; and,
- there is a lost sense of reality or "abnormal state of mind".

A small number of these submissions specifically identified that there needed to be actual or immediate harm as opposed to there being a risk of harm. Concern was raised about concepts of 'dangerousness' and 'risk' and attempts to assess and predict risk.

A small number also made the distinction between danger and harm to others as opposed to self, and included the view that compulsion was inappropriate for people who were suicidal.

In addition to criteria relating to extreme circumstances and situations of last resort, many submitters identified a lack of decision-making capacity as a core criterion, and with reference to supported decision-making and advance directives. Other related considerations mentioned included:

- determining whether treatment was required imminently or could wait until capacity had restored;
- collective decision-making with trusted people alongside professional opinion;
- the individual's views, beliefs and preferences remaining central to the decision-making process;
- explicit recognition that mental illness does not equate to a lack of capacity; and,
- lack of capacity being due to the mental condition.

Some of the submissions articulated core principles that should inform the use of compulsory treatment. These most commonly related to:

- maintaining dignity – compulsory treatment should be delivered in the most supportive and humane ways possible;
- do no harm – the experience should not leave tāngata whaiora in a worse position;
- likely to benefit – treatment is likely to benefit the individual and will be in the best interests of the tāngata whaiora;
- transparency – full information, and involvement of tāngata whaiora;
- respect – respecting the opinions of tāngata whaiora; and,
- requiring a high threshold – a high threshold and standard of objective evidence to justify compulsory treatment.

Where should compulsory treatment be allowed to occur?

Just under half of the written submissions responded to the question about where compulsory treatment should occur if it is allowed by the legislation. The majority of responses came from tāngata whaiora and whānau.

There was much variation across the written submissions about where compulsory treatment should occur. There was, however, consensus that:

- there should be a range of settings available;
- the selection of which should depend on the preferences of tāngata whaiora (and their whānau); and,
- the options that will provide the most appropriate treatment support.

From both consultation hui and written submission stakeholders asserted that compulsory treatment settings should be therapeutic and feel familiar, safe, and welcoming to tāngata whaiora.

We heard that care environments should embed te ao Māori and tikanga practices with physical facilities designed around te ao Māori. We also heard that tāngata whaiora Māori should have the choice of, and be connected to, Māori owned and run facilities and services.

We also heard that community settings should be equally available as hospital settings. We heard that tāngata whaiora should not be in hospital for long periods of time. Concern was raised at the inadequate state of hospital and inpatient facilities, which were not conducive to safety, wellbeing, treatment and recovery.

Which health professionals should be allowed to assess?

People were asked which health professionals they believed should be allowed to assess whether a person needs compulsory mental health treatment.

Around a third of written submissions responded to the consultation question about who should be allowed to assess whether a person needs compulsory mental health treatment if allowed by the legislation. The submissions identified a range of mental health and health professionals who should be allowed to assess the need for compulsory mental health treatment, with no particular consensus on any one specific health professional that should fulfil this role. Indeed, many of the submissions identified a combination of health and mental health professionals such as general practitioners, counsellors, social workers, nurses, psychiatrists and psychologists. It should be noted that the majority of written responses to this question came from tāngata whaiora and family and whānau.

Of importance for some of these submissions was that assessment should involve a group or multidisciplinary team approach, as opposed to one professional alone undertaking the assessment. Some also identified the involvement of family, whānau and significant others in the assessment process.

Some of the submissions stated that those undertaking the assessment should be trained and experienced and/or specialised in mental health assessment, including crisis assessment, and culturally competent.

Safeguards

Across stakeholders, multiple concerns were related over a lack of protection of tāngata whaiora. From many participants from the mental health sector consultation hui we heard concern:

- that some people have been placed under the Act because of an erroneous interpretation of an individual's presentation, and importantly, factors that occur outside of the legislation as there was no perceived risk to self or others or an inability to care for oneself. We heard concern that that compulsion-based decisions have been made on the basis of the individual's perceived aggression, rather than actual aggression;

- that decisions pertaining to compulsion have been made according to the clinician's subjective assessment. In these cases, we heard that people have been placed under the Act for the purpose of receiving perceived essential treatment;
- about these decisions because, in many situations, participants considered there was insufficient or no effort made to understand their perspectives or gather the perspectives of significant others and peer support workers. In these situations, we also heard that people have been coerced by mental health professionals to go under the Act; and,
- that restrictive practices often occur because of insufficient staff resourcing. As a result we heard that restrictive practices are not necessarily based on an individual's risk but are a response to the allocation of resourcing. We heard, therefore, that such decisions should be viewed as an infraction of human rights.

Within this context, and from both consultation hui and written submissions, a number of suggestions were made to safeguard assessment, decision-making and compulsory practices. These included:

- mental health legislation should explicitly state that tāngata whaiora are entitled to the provision of full information to enable them to participate in decision-making processes, to make fully informed decisions, and to ensure informed consent. Tāngata whaiora should have the right to choose and refuse treatment based on full information. Tāngata whaiora need to be fully informed about the process and what will happen, including the benefits and disadvantages of different decisions;
- for tāngata whaiora Māori, we heard that tāngata whaiora, whānau, hapū, and Iwi should be fully informed and empowered to participate in assessment processes and to be a part of decision-making;
- compulsion should be time limited and of a shorter duration. We heard that such time-related requirements should be clearly stated in mental health legislation;
- assessment and service provision needs to view tāngata whaiora holistically and thereby remove classifications, arising out of competitive funding models, that result in siloed and disparate service delivery (for example the individual having to access different service providers for diabetes and mental health). We heard that removal of artificial classification would significantly contribute to the delivery of seamless care and wrap-around support across services, systems and the sector in general;
- while compulsion is a complex issue, decisions surrounding intervention should align with an individual's wishes, including whether the individual dictates that compulsion is appropriate in the event they experience acute mental distress. In this regard, we heard that advance directives are important and they should be appropriately and consistently implemented and monitored. We also heard that mental health legislation should prevent clinicians from overriding advance directives;
- there needs to be better reviews and safeguards embedded in a mental health system that is supportive of the individual. We heard that there needs to be better

"safety nets" surrounding assessment and the use of compulsory treatment orders. We heard that provision needs to be made for -

- second opinions that are viewed by tāngata whaiora and their whānau as truly independent,
- timely investigations of complaints or issues as they arise, and
- requiring clinicians to evidence their prescribed treatment is in accordance with best practice.
- treatment should be independently reviewed to ensure it adheres to best practice; and,
- family, whānau and significant others should be given the right to "audit" services.

Tāngata whaiora always supported

We heard that tāngata whaiora should always have easy access to proactively offered peer and cultural support, as well as independent advocates. This is important to ensure appropriate support and advice, and that rights and processes are fully understood. There should be access to free legal services and legal representation.

> *I think what would really help in the future with the Mental Health Act is for someone like me who is distressed to be able to have somebody to walk alongside me as I'm going through any kind of process. Somebody who's been through the system… Somebody who understands and somebody who's able to navigate that system with me. A peer support worker is what I would like. (Mental Health Professional Body, Written submission)*

To reflect te ao Māori, we heard that tāngata whaiora should have the right to access cultural and spiritual supports from the outset and across the spectrum of treatment (including kaumātua, tohunga, kaiawhina). There should also be automatic provision of cultural support so that tāngata whaiora Māori never go through compulsion processes in isolation and have access to culturally appropriate care and support.

The centrality of whānau

From consultation hui the centrality of whānau and the importance of whānau as essential to the individual's wellbeing was emphasised. From Māori and Pasifika participants we heard that such a holistic focus means that a collective notion of self needs to be included in mental health legislation to reflect whānau as an essential component of engagement, decision-making, advocacy and support.

Across consultation hui stakeholders we heard that mental health legislation should specifically acknowledge children and young people within definitions of whānau. Such inclusion acknowledges that young people and children, and not exclusively adults, can provide support.

We heard that mental health legislation should acknowledge that the wishes of tāngata whaiora about the inclusion of whānau should be paramount in terms of decision making, capacity assessment, treatment and support in general. This was considered important because it cannot be assumed that all tāngata whaiora have a positive or supportive relationship with their whānau. Mental health legislation should explicitly allow for significant others, as defined by tāngata whaiora, to be part of the decision-making process.

We also heard that tāngata whaiora are part of a family system and mental health legislation should include provision to support the whānau; the rationale of which is that whānau often provide support to their loved one which can have an impact on their own wellbeing. For example, the need for support and respite was especially noted for older whānau members.

Provision for culturally appropriate responses

Stakeholders considered that prejudice and racism have often underscored mental health assessments, whereby tāngata whaiora have been placed unnecessarily under the Act. We heard of staff failure to engage in de-escalation processes or a lack of knowledge about how to engage in de-escalation in order to calm the person so that an assessment can be undertaken. We equally heard that a contributing factor to the disproportionate number of Māori being placed under the Act can be due to mental health staff lacking cultural knowledge and failing to engage tāngata whaiora in an appropriate manner.

We heard that processes leading to someone being placed under the Act can be rushed and decisions can be made without the input of whānau and without cultural expertise. We heard that the inclusion of the perspectives of whānau and those with cultural expertise will ensure sufficient context is provided to contribute to appropriate decision-making. We also heard that a model of care needs to be implemented that is founded upon respect, time taken to know the individual and understanding their life course (whakapapa) and needs.

We heard there needs to be access to Māori healing practices and pathways outside of the mainstream medical approaches. Tāngata whaiora Māori should have the choice of western or Māori approaches. We further heard that mental health needs to be understood and responded to from a te ao Māori perspective and within the context of Māori models of health.

Cultural assessment

Stakeholders, in both consultation hui and written submissions, identified the need for increased use of cultural assessments. Such need is based on concern that:

- the privileging of western biomedical approaches have marginalised Māori;
- section 5 of the Mental Health Act, which makes provision for the respect and acknowledgement of the culture needs of a person, is insufficiently defined and has been inconsistently applied across the motu;

- cultural assessments are not a legislative requirement yet cultural assessments are essential to providing an appropriate understanding, context and lived experience of tāngata whaiora and whānau.

We heard that mental health legislation should:

- specify the requirement for cultural assessments;
- be linked to protection-related Treaty obligations;
- require cultural assessments to be considered in all decision-making, equitably against psychiatric assessments;
- specify a quality standard that cultural assessments need to attain. The requirement for such standards is based on concern that there is a high degree of variable quality across mental health sector cultural assessments;
- require cultural assessments to be holistic and include psychological, cultural, and spiritual considerations;
- include provision for increased resourcing to ensure cultural assessments are conducted to a high standard and undertaken by culturally competent practitioners.

Court engagement

We heard that court-related processes are intimidating for tāngata whaiora and whānau. We heard that judicial processes need to be person- and whānau-centred and above all adhere to mana enhancing practices. We heard that mental health legislation should make provision for such practices.

Mental health workforce

We heard that mental health staff lack cultural competency, which when coupled with the predominance of western biomedical models, continues to result in the misdiagnosis of Māori as "mentally ill". We heard that mental health legislation should require mental health providers to demonstrate cultural competency.

We heard that tāngata whaiora Māori should have access to Māori practitioners skilled and knowledgeable in te ao Māori and te reo Māori to ensure cultural perspectives are brought to care, assessment, treatment, and support, and to ensure cultural appropriateness

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PREVENTING COERCION IF COMPULSORY TREATMENT IS NOT ALLOWED

Submitters were asked what requirements should be in legislation to prevent an individual being coerced into accepting mental health treatment they might not want. While responses varied, key themes that emerged related to the need for:

- adherence to a human rights framework;
- provision of adequate supports;
- whānau to have an integral role in supported decision-making;
- community-based support and treatment options; and,
- legislated advance directives.

If new mental health legislation did not allow the use of compulsory treatment, written submitters were asked what requirements should be in legislation to prevent an individual being coerced into accepting mental health treatment they might not want.

Around half of the written submissions responded to this question. While responses varied, key themes that emerged related to the importance of informed consent, the provision of adequate supports, the integral role of whānau in supported decision-making, community-based support and treatment options, and the role of advance directives. A small number responded to this question to reiterate a need for there to be some compulsion.

Adherence to a human rights framework

The theme most commonly referenced, across stakeholder groups, was the prevention of coercion by adhering to a human rights framework. Such adherence will ensure tāngata whaiora have the right to:

- provide informed consent and that consent is continual, meaning that it is not all encompassing, and is sought for each decision that needs to be made;
- full information about their rights;
- make their own decisions;
- choose and refuse treatments;
- full information about how to make a complaint;
- be supported in the decision-making process; and,
- have information provided in accessible formats and in their preferred language.

Individual supported

Around a quarter of written submissions considered that coercion could be minimised through the legislative provision of cultural advisors, peer support workers, independent peer advocates, the purpose of which is to:

- ensure the individual is aware of their rights;
- discuss treatment concerns and options;
- provide support to empower tāngata whaiora to make decisions; and,
- assist the tāngata whaiora to access complaints processes.

We heard of the need for the individual to be provided free legal advice and aid. We heard that advocates need to be appropriately trained and skilled, aware of mental health issues, the importance of a person-centred approach and with sufficient cultural knowledge to best serve the needs of tāngata whaiora and their whānau.

Family, whānau and significant others

Around a quarter of the written submissions stated that coercion could be minimised by including family, whānau and significant others in the decision-making process. We heard support for collective treatment planning and decision-making processes, inclusive of independent peer advocates and supports, cultural advisors and clinicians. Within this process it was acknowledged that the wishes of the individual, family and whānau should be prioritised.

Community-based support and treatment options

We also heard, including from mental health professional bodies, that the prevention of coercion would require the provision of a wider range of community treatment options, and importantly in rural areas. It is acknowledged that this will require heavy investment to provide care and support early in the community, in culturally appropriate ways, and matched by staffing levels.

We heard there is a need for greater collaboration and input across specialty community services and that these services should be connected, resourced, multidisciplinary, peer-led, and rely on a recovery model.

Advance directives

Interrelated within the above themes, we also heard that coercion can be minimised through the universal use of advance directives. Please see section 10, Supported Decision-making, for a discussion of the benefits of advance directives.

TE TIRITI O WAITANGI

The importance of embedding the articles, principles, and intent, of Te Tiriti o Waitangi (Te Tiriti) in all aspects of new mental health legislation was commonly shared. In particular the need to:

- explicitly reference the articles and principles of Te Tiriti ;
- clearly determine how these articles and principles will be embedded across the legislation;
- articulate what this means in practice, namely expectations, required actions and accountabilities; and,
- ensure legislation is grounded in te ao Māori.

In addition, it was strongly suggested that:

- legislation should be co-created and written in partnership with Māori and tāngata whaiora;
- legislation acknowledge the integral relationship between Te Tiriti, kawanatanga, tino rangatiratanga and ōritetanga and the person's connection with their wairua, values and beliefs from a Māori worldview;
- legislation should be drafted with reference to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP);
- Te Tiriti, if correctly embedded within the legislation, would simultaneously benefit tauiwi (non-Māori) by reinforcing holistic approaches to wellbeing;
- through embedding the principle of partnership, new mental health legislation will provide an essential opportunity for tāngata whaiora Māori to actively participate in the ongoing development of mental health responsiveness;
- Te Tiriti should be embedded into guidelines arising from mental health legislation to guide implementation;
- adherence to the principle of equity, and the achievement of equitable outcomes for Māori, requires appropriate resourcing;
- there needs to be appropriate checks and balances to monitor and ensure mātauranga Māori and Te Tiriti articles and principles and requirements are being honoured.

Rather than a last resort mental health option, we heard that the focus of mental health legislation should be about supporting tāngata whaiora in the widest sense of their wellbeing, beyond a simplistic notion of mental health. To achieve this a number of central te ao Māori tenets (inclusive of include Tiriti principles and aspects of the articles of Te Tiriti) were identified (see Table 8.1).

Across stakeholders, we heard acknowledgement and recognition of Māori overrepresentation in the mental health system and that the impact of colonisation and racism cannot be underestimated.

We heard from some, through both written submissions and the consultation hui, that new mental health legislation needs to explicitly acknowledge inequities, racial disparities and intergenerational trauma experienced by Māori. We heard that such acknowledgement would provide a foundation for new mental health legislation to address the inequitable position of Māori within legislation and practice.

We heard that there is a need to appropriately support people's oranga tonutanga (sustained wellbeing). However, stakeholders also identified a number of failures within the wider health system that have acted to prevent tāngata whaiora receiving support early and, as a consequence, their situation worsens to the point that they encounter mental health services in a time of crisis.

We heard that the rights to early intervention and support is guaranteed under Te Tiriti.

Embedding Te Tiriti o Waitangi in mental health legislation

> *Any transformed mental health system must have Te Tiriti and its principles as its foundation. Te Tiriti must therefore, be expressly and unambiguously provided as a foundational and central component of the new legislation. (Written submission, Kaupapa Māori Body)*

Across consultation hui and written submissions we heard of the importance of embedding the articles, principles, and intent of Te Tiriti in all aspects of new mental health legislation.

Stakeholders also stated that there needs to be explicit reference to the principles of Te Tiriti, clearly stating how they will be embedded across the legislation and what this means in practice, namely expectations, required actions and accountabilities. We further heard that the legislation needs to be grounded in te ao Māori.

Practical ways or guidance to embed Te Tiriti and its principles included consideration of:

- the Waitangi Tribunal's report Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575);
- Hua Oranga, a tool to measure mental health outcomes for Māori developed by Te Kani Kingi and Tā Mason Durie;
- the Tiriti o Waitangi framework outlined in the Ministry of Health's "*Whakamaua: Māori Health Action Plan 2020-2025*"; and
- the principle of mana-enhancing practice required under s3(d) of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

Across consultation hui and written submissions, a strongly expressed expectation was that legislation should be co-created and written in partnership with Māori and tāngata whaiora.

From Māori we heard of the integral relationship between Te Tiriti , kawanatanga, tino rangatiratanga and ōritetanga and acknowledging the person's connection with their wairua, values and beliefs from a Māori worldview.

From the consultation hui we also heard that He Whakaputanga (Declaration of Independence, 1835) needs to be included in legislation as the founding document of Aotearoa New Zealand. We heard that this is especially essential because He Whakaputanga reinforces the rights of tino rangatiratanga.

We also heard that mental health legislation should be drafted with reference to UNDRIP.

Across consultation hui and written submissions, we heard that Te Tiriti should be reflected in the development of Māori-centred legislation, with the understanding that Te Tiriti, if correctly embedded within the legislation, would simultaneously benefit tauiwi (non-Māori).

In particular, we heard that the embedding of Te Tiriti in new legislation would benefit vulnerable populations by reinforcing holistic approaches to wellbeing. We heard support for this approach on the basis that Māori will continue to experience inequities if legislation adopts a simplistic approach of attempting “to put a Māori lens across” legislation.

We heard acknowledgement of the inequitable experiences of tāngata whaiora Māori and the even greater vulnerabilities of disabled tāngata whaiora Māori. Within the context of Te Tiriti, and the principle of partnership, we heard that new mental health legislation provides an essential opportunity for tāngata whaiora Māori to actively participate in the ongoing development of mental health responsiveness. In this sense, we heard that tāngata whaiora Māori are an essential participatory voice in the design, implementation, and process-related reviews.

We further heard that Te Tiriti needs to be embedded into guidelines arising from mental health legislation to guide implementation.

We also heard that adherence to a principle of equity, and the achievement of equitable outcomes for Māori, requires appropriate resourcing.

Monitoring

Submissions identified the need for checks and balances to monitor and ensure mātauranga Māori and Te Tiriti principles and requirements are being honoured.

> *There needs to be legislative accountability for practitioners to incorporate principles of mātauranga Māori and Te Tiriti into their practice, otherwise the system will continue to fail our people. (Written submission, Kaupapa Māori body)*

Supporting tāngata whaiora Māori

Rather than a last resort mental health option, we heard that the focus of mental health legislation should be how to support tāngata whaiora in the widest sense of their wellbeing, beyond a simplistic notion of mental health.

To achieve this, we repeatedly heard that there are a number of central te ao Māori tenets that the new legislation should incorporate. It is noted that these include Tiriti principles and aspects of the articles of Te Tiriti (see Table 8.1).

Table 8.1: Central te ao Māori tenets that the new legislation should incorporate

Te ao Māori tenet	**Description**	***Quote***
Tino rangatiratanga	There is a need to ensure the legislation provides Māori with the ability to develop their own kaupapa Māori responses, namely Māori addressing and responding to the needs of Māori. We heard that a kaupapa Māori response reflects articles of Te Tiriti which give protections to the rights of Māori for their own parallel responses. We heard that this requirement is in response to the privileging of western medical models that have been imposed with the exclusion of Iwi, hapū, Māori providers and whānau. We heard that communities should be empowered to develop their own responses. In this sense there is a call to devolve mental health service provision to Māori. We heard, historically, responses have been professionally developed and led; reflecting the privileging of western medical models. These approaches have not been successful. We heard that there is recent evidence for community-led responses in light of community responsiveness to COVID-19.	*I have been saying all the way along, in order to maintain the dignity and mana of whānau that was in the Mental Health Act guidelines that Māori led by Māori with Māori for Māori. And that has to be prescriptive within the Mental Health Act guidelines. (Mental health sector, Māori consultation hui)* *In terms of really doing something that's going to give that systematic change, that transformation, you know, I feel that this needs to be brought back to the community. Community needs to be making decisions about what's going to work for them. You know, that's been a problem. We've had the bureaucrats making these decisions, and they've had the chance, you know. They've had the chances, they've had the opportunities for God knows how long, you know. It's time to give the power to the communities. That to me, requires us to start devolving the services, the supports and the funding, and how those decisions are made, you know, that part of it is again, you know, the Ministry needing to let go….. trusting in our communities, trusting in our communities, we have the capability, capacity out in our communities, to make these decisions. (Mental health sector, Māori consultation hui)*

	Submitters recognise that this will require substantial shifts in decision-making to ensure mana whenua have equal authority and adequate resource and investment to enable tino rangatiratanga and mana motuhake.	
Rangatiratanga[2] *of tāngata whaiora*	Rangatiratanga was raised in regard to individual sovereignty and that this is reflected in the validity and importance of tāngata whaiora voice. We heard that upholding tino rangatiratanga would provide a significant shift from the current legislation. We heard tino rangatiratanga involves safeguarding the needs and enhancing the mana of tāngata whaiora while working in partnership with whānau. We heard tino rangatiratanga means that tāngata whaiora have the right to make their own decisions.	*We believe in tino rangatiratanga - the right of all people to self-determine their futures and have autonomy over their mind (hinengaro), spirituality (wairuatanga), physical health (tinana), family/relationships/sense of connectedness (whānau), and our connectedness to our lands (whenua and turangawaewae). (Written submission, Kaupapa Māori body)* *I say tino rangatiratanga means that Māori have the authority, that tāngata whaiora need to have a voice wherever you want to make decisions about care of our people. Māori need to sit alongside you so their voice can be heard, and it's just as strong as yours. That's tino rangatiratanga … (Mental health sector, Māori consultation hui)*

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[2] Consultation hui participants and submitters spoke about tino rangatiratanga in relation to individuals. It is acknowledged that rangatiratanga is typically understood to be about collective rights (for example, tāngata whaiora in the context of their whānau, hapū and Iwi) and not in relation to an individual's rights.

	Different written submissions described tino rangatiratanga of tāngata whaiora in practice as including: self-determination, self-direction, choice, and knowledge of appropriate steps. Having options, choices and giving consent; maximum autonomy by supporting tāngata whaiora to make treatment decisions that reflect their needs, aspirations, cultural context	
Whānau	We heard that whānau is a central tenet of te ao Māori and that whānau need to be included in all aspects of supporting tāngata whaiora. The Mental Health Act and its application was heavily criticised for not placing significant weight on whānau voice. Notably, we heard that for non-Māori, family was equally regarded as essential. Adherence to the tenet of whānau ensures whānau are included and have the means and opportunity to fully participate in decision-making, treatment and support of tāngata whaiora. We heard the essential nature of whānau inclusion rests in the strength of collective decision-making. It is essential to appropriately engage whānau in a mana enhancing way. In addition, whānau should	*One of the most important things to consider from a te ao Māori perspective is that whānau and connecting therapeutically to whānau is important in particular whakapapa. Whakapapa is one of the main cornerstones to Māori culture and identifies who we are and where we come from. Understanding this process means that all efforts need to be made to connect people to whānau, in a genuine and sincere manner. Most times people take short cuts to 'tick a box' but our understanding is that recovery hinges on being able to determine who you are and where you come from. (Written submission, Kaupapa Māori Body)* *I think that if we strengthened family whānau engagement in our processes, that would also help. And that's something which, you know, I know, I know, the Ministry and individuals are having a focus on but you know, we need that to come through. I know it is*

	be empowered to make decisions about the needs and health of the tāngata whaiora in the event that the individual is not in a position to make decisions for themselves. We heard that provisions need to be made for whānau to able to be with tāngata whaiora while they are in acute care and that whānau need to be appropriately welcomed through tikanga into the process, and fully supported as needed to support their whānau member. Associated important te ao Māori values and principles identified by written submissions include: Collectivism and including recognition of the role of families, whānau, and communities, hapū, Iwi in all stages (partnership). We heard of the legislation’s potential to embrace both individual and collectivist worldviews; Whanaungatanga and whakawhanaungatanga; Time, space and place to welcome and engage whānau and to provide full information to support and inform their understanding and role in the journey (to empower whānau); Adherence to tikanga; and,	*in the mental health [Act] but I think it could be a stronger part of it. (Mental health sector consultation hui)* *We need to hand the power to whānau. It's almost like we're police officers, you know, the minute we walk in, and we've got all this power, and instantly that person's mana is removed. And that the sense of whānau being able to kind of support that person's journey through the system is also removed. And actually, that's the kind of stuff that that, from my perspective, being able to hand those decisions back to the whānau and saying, we like, well, this is kind of the legislation, actually you have some choice around this. And where do you want your persons treated them however you want that manage them, because we don't do that we'd like Come with us, we're gonna read your rights and off you go to seclusion and nobody can know anything. Until we say, and that is for me, it's always part of, of what we do. So I think being that, yeah, definitely hand that back. And work in that way. would be very, very different. Yeah. (Duly Authorised Officer consultation hui)* *… to also embrace a te ao Māori perspective, it guarantees that whānau will be included and involved in the way they should already be. (Family and whānau consultation hui)* *When I'm unwell, people keep trying to push me to make decisions, which actually you have never even been asked to do. And they keep just saying, you're responsible, you're the individual, you need to make these choices. And I actually cant. one of the*

	Mana enhancing practices – including mana of the whānau honoured by enabling whānau-led solutions. Mana of the person is protected by working with the whānau.	*problems is one day, I think one thing and next I'll do another one, it really interfered with everything and let you actually my family and my the people around me had a really good picture of what needed to happen. So the individual stuff, I think they need to take that independent word out and change it. And I think what comes up in kaupapa Māori stuff would actually work for the whole of New Zealand, in terms of being more collective and more shared decision-making, and that sort of stuff and recognizing that when people are unwell. Like my family know what I want long term, but what how I can communicate that when I'm actually in a really bad place doesn't work. And in terms of the least restrictive practices, I'm fighting and battling because I want to remain independent. But really I have a choice. I'm saying, I know my decision-making and what's happening for me at the moment is impairing what I really want. And actually, so I can't focus on all these other choices. And choice for me is to hand over to my family and to my people that I trust, it is a choice to say I want them to be making some decisions for me. And I kept getting being pushed into making decisions. (Lived experience, disabled person, consultation hui)*
Mātauranga Māori	Provision for the treatment of tāngata whaiora should include the choice to engage in in te ao Māori practices. Tāngata whaiora should be connected to Māori services and settings so that choice is enabled. Tāngata whaiora should have choice in their place	*Legislators now need to be courageous and go further – wherever there is inclusion of clinical practices, these need to be placed alongside equal cultural practices and given equal consideration so that this better demonstrates 'proper recognition'. If there is a clinical assessment required, then a cultural assessment should be required. If a clinician needs to assess an individual, then a cultural expert also needs to assess an individual. Where there is clinical*

	of treatment and one where they feel comfortable, safe, and protected. We heard that legislation should include provision for the equivalency of Māori cultural assessment, treatment, and practices, such as rongoā Māori, tohunga and nga ringa whakahaere. We heard that mental health legislation should ensure clinical environments include provision for kaumātua and tohunga. We heard support for cultural assessment to be accorded equal weight as psychiatric assessment. We heard support for the primacy of cultural assessments (by practitioners skilled and knowledgeable in te ao Māori and te reo Māori) that are routine and support culture, beliefs, and norms to be understood from initial engagement to completion of care.	*decision making as part of any new intended process, then cultural decision making also needs to occur. (Written submission, Kaupapa Māori body)* *Our rongoā practitioners That are actually enough - I think about the Treaty of Waitangi - in the value, that see the value, shouldn't be in a support role for many of these. These are your, we have our own technical specialists and clinicians in their own rights. And we need to whakamana those knowledge streams. And, you know, I think we often talk about these as being support roles, and no disrespect, but the westernised clinical space takes precedence. And I actually think threy can be a rejigging and reorganization. Because if we're thinking about what is really meaningful for our whānau, and the pathways for our family, this absolutely comes from the expert knowledge of our people. They can make a real difference. So yeah, just leading onto what you're saying. And I know that the Health Practitioners Competency Assurance Act is there, you know, and we used to see some stuff back in the day they were not seeing so much anymore, but I just I think that there might be some room maybe to look at it quite differently in whakamana that space. And so there's some accountability to services. (Mental health sector, Māori consultation hui)* *A lot of the health system doesn't always relate to mātauranga Māori. Healing can happen when whaiora engage with the natural environment. Like going back to the marae, the river, the mountain (Mental health sector consultation hui)*

Protection	We heard concern about the lack of cultural awareness amongst those who work in the mental health sector. Reference was made to the principal of protection to underscore the requirement that health and mental health staff are appropriately trained to acknowledge different cultural values and confronting, and working through, racism that can affect clinical and supportive practice. That the mental health workforce should be developed to respond to, and work within, te ao Māori healing practices and mana enhancing processes. We heard of the need for provision of kaiawhina, kaiārahi, cultural advisors, takawaenga, advocates, and Māori peer support to respond to the needs of tāngata whaiora. The need for cultural experts to be readily available to advise clinicians was also identified. We also heard of the importance of the inclusion of kaumātua across the continuum of care to support adherence to a holistic appreciation of the individual’s needs and tikanga and the provision of advice and support.	*We recommend the increase in Māori models of health amongst all health workforces and mental health services with an increase in Māori Workforces. Especially, Kaumatua and Kuia to be available across the continuum of care to ensure we have the ability for out holistic health to be addressed; for our culture to be respected, and to gain advice and support when needed (Written submission Kaupapa Māori Body)* *I think it's really about addressing internalized racism that practitioners have and they may not necessarily hold you know, racist perspectives, but we all breathe and racist air because of colonization. So I think it's really important for anybody working on the ground to have space to be able to sort of flesh that out and understand their own internal biases and what to do with them. (Family and whānau consultation hui)*

	Special mention was made of the need to ensure sufficient staffing of kaiawhina, and cultural advisors and experts occurs during evenings and weekends (24 hours). We heard of the need to invest in, and build, the Māori heath workforce to ensure that Māori cultural practitioners and expertise is integral.	

CAPACITY AND DECISION-MAKING

There were mixed views about the need for a test of capacity as an element of compulsory treatment. From the majority of participants, however, we heard support for the introduction of a test of decision-making capacity.

Considerations by those supporting the inclusion of capacity

- definitions of capacity need to be aligned across legislation, for example, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and Protection of Personal Property Rights Act 1998;
- at a minimum, capacity should be an integral component of the assessment process;
- new mental health legislation should require capacity to be reviewed at regular intervals and consider how a clinician would make decisions in cases of fluctuating capacity. The regular review of capacity is important as it acknowledges that the individual may demonstrate decision-making capacity after a relatively short amount of time.

Considerations by those who were less supportive of the inclusion of capacity

- the introduction of a test of capacity could lead to risk, namely the possibility that someone might meet a test of capacity but be a risk to themselves or others;
- because the Act can only be used in acute situations it would therefore be rare for capacity to be present at these times;
- caution is needed as inclusion of decision-making capacity as a legislative requirement may result in superficial and administratively burdensome processes centred on the avoidance of risk; and,
- there are potential problems with the definitions surrounding capacity. This was especially raised in non-acute situations (such as eating disorders) when an individual has decision-making capacity but chooses not to engage in treatment. In these situations, the introduction of capacity would result in an inability for clinicians to make treatment compulsory.

Tests of decision-making capacity – issues to be resolved

Despite some support for the introduction of a test of decision-making capacity there was uncertainty:

- about how capacity assessment might be operationalised. Specifically, how a capacity test would work, what the requirements would be and who could assess capacity in a way that would effectively contribute to the safety and treatment outcomes of tāngata whaiora;

- surrounding situations of acute presentations in emergency departments and the difficulty of incorporating the holistic perspectives of others at such times;
- about how important environmental or situational contexts within which capacity is assessed will be considered and taken into account; and,
- given that disabled people are at particular risk of having capacity inappropriately assessed.

Who should assess whether a person has decision-making capacity?

Stakeholders generally agreed that capacity should not be solely determined by a clinician. Rather, capacity should be determined through a holistic process that centres on the individual's capacity and draws on the perspectives of cultural advisors, cultural practitioners, kaimahi, clinicians, tohunga, legal experts, significant others, and independent peer advocates who can support holistic decision-making around the needs of tāngata whaiora.

The presence of insufficient decision-making capacity was expressly identified as a key consideration by a small number of written submissions responding to the question about when compulsory treatment should be allowed. Of interest, these submitters were mainly academics, persons working under the Mental Health Act, and government agency stakeholders.

Across the consultation hui we heard mixed views on the need for a test of capacity as an element of compulsory treatment. However, in the main, stakeholders were supportive of the introduction of a test of decision-making capacity. This section first describes considerations raised by those who support the introduction of a test of capacity. This is followed by a discussion of reasons underpinning a rejection of a test.

Considerations by those supporting the inclusion of capacity

Stakeholders who supported the inclusion of capacity in new mental health legislation were of the view that:

- definitions of capacity need to be aligned across legislation, for example, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and Protection of Personal Property Rights Act (1998);
- at a minimum, capacity should be an integral component of the assessment process; and
- new mental health legislation should require capacity to be reviewed at regular intervals, and consider how a clinician would make decisions in cases of fluctuating capacity. The regular review of capacity is important as it acknowledges that the individual may demonstrate decision-making capacity after a relatively short amount of time.

Stakeholders who supported a capacity test in legislation also raised a number of concerns:

- while lived experience consultation hui participants generally agreed with the inclusion of a test of capacity, we heard that capacity needs to be appreciated within a mental health system that has often not provided the individual with early intervention and support; despite the individual’s repeated efforts to access support. As a consequence, a person’s condition may have deteriorated to a point of being placed under the Mental Health Act. Within this context, participants considered that early intervention and support would have greatly reduced questions of capacity in times of crisis;
- those with lived experience stressed that the western biomedical model commonly prevents the negatively “labelled” individual’s ability to make their own decisions. We heard that disempowerment begins at the point of assessment and it taints how mental health clinicians understand a person’s insight and is then used as justification for questioning a person’s perspective on almost everything, including their decisions. It also taints how a person’s complaint is listened to, or whether any accommodations are made to meet their self-defined needs. Further, it was considered that poor practice, including racism and cultural incompetence, often results in hastily derived diagnoses and treatment plans. This practice is in contrast to the wishes of those with lived experience who advocated for a change in the way clinicians engage with those experiencing distress or mental unwellness which currently results in the individual’s wishes being overridden. We heard from those with lived experience that this shift requires clinical staff spending longer periods of time with the individual and a commitment to understanding the individual’s experiences, needs and wishes; not limited to the individual clinician’s diagnosis.
- some family and whānau hui participants stressed that the absence of a test for capacity reflects coercive healthcare practice. In this context, coercion needs to be appreciated as an infringement of the rights of tāngata whaiora.
- some mental health sector consultation hui participants considered that mental unwellness is episodic and placing someone under the Act can have long-term implications, such as an impact on employment opportunities.

Considerations by those who are less supportive

Consultation hui participants who were less supportive of a test of capacity stressed that that those who fall under the Act are in crisis and have been determined to be a risk to themselves or others. Within this context, and from some of the written submissions, we heard:

- the introduction of a test of capacity could lead to risk, namely the possibility that someone might meet a test of capacity but be a risk to themselves or others. Some written submissions referred to tensions where there is capacity, but the individual wishes to end their own life or is extremely unwell, and refusing treatment and support;

- from the mental health sector we heard that the Mental Health Act can only be used in an acute situations, and as such, it would therefore be rare for capacity to be present at these times;
- some from the mental health sector cautioned that the inclusion of decision-making capacity as a legislative requirement may result in superficial and administratively burdensome processes centred on the avoidance of risk;
- of possible problems with the definitions surrounding capacity. This was especially raised in non-acute situations when an individual has decision-making capacity but chooses not to engage in treatment. In these situations, the introduction of capacity would result in an inability for clinicians to make treatment compulsory; and,
- from some family and whānau that a test of capacity would place tāngata whaiora at risk. We heard that such risk can be understood in light of family and whānau belief that their loved ones would have demonstrated capacity while in a severely unwell state.

Tests of decision-making capacity – issues to be resolved

Despite some support for the introduction of a test of decision-making capacity we also heard a high degree of uncertainty from the mental health sector about how capacity assessment might be operationalised. Concern was raised over how a capacity test would work, what the requirements would be and who could assess capacity in a way that would effectively contribute to the safety and treatment outcomes of tāngata whaiora. Without such assurances, mental health sector participants feared that tests of capacity might fall under an administrative process that does not sufficiently address the needs of the individual. This was especially raised in relation to the tension between an individual who meets a measure of capacity while posing a possible risk to themself or others.

We also heard from consultation hui participants and written submissions:

- uncertainty surrounding acute presentations in emergency departments and the challenges of incorporating the holistic perspectives of others at such times;
- that the environmental or situational context within which capacity is assessed is important. For example, capacity should be assessed after best de-escalation efforts have been made, and the environment in which the individual has been brought needs to support emotional de-escalation. We heard the following factors need to be considered as negatively impacting on the assessment process: power dynamics, environment and communication; and,
- that disabled people are at particular risk of having capacity inappropriately assessed. This was especially raised in relation to those with neurodiverse conditions, where the physical environment, leading to sensory overload, can act to exacerbate what might appear as presenting symptoms and negatively impact on the

individual's ability to demonstrate capacity. We also heard that accommodation is required for people who are deaf, non-verbal, or temporarily lose the ability to speak (such as with neurodiversity). Within these contexts, staff need to be trained in sign language and assisted or augmented technology should be readily available.

What matters should be relevant to capacity assessment

Against the above context, it is of use to consider the views of written submissions in terms of what matters should be relevant to a capacity assessment. While around half of submissions responded to this question, a wide range of views and responses were provided, with a few different overall considerations identified, including that the starting point should be a presumption of capacity.

Some considered that some or all of the four current health criteria for the assessment of capacity – being able to understand, remember/retain and weigh-up information and communicate choice – outlined in page 31 of the public consultation discussion document (and reflected in s9 of SACAT), were appropriate criteria for capacity assessment, or would be with varying qualifications. Examples of possible qualifications included:

- being explicit that the criteria were not to be assessed when a person was substance affected;
- ensuring the assessment occurred at regular intervals and key decision points, knowing that capacity can fluctuate; and
- whether the assessment would require tāngata whaiora to demonstrate the criteria with or without support.

> *However, any assessment of capacity would need to be understood within a social model of disability. Capacity testing that uses a social model framework would not be inconsistent with the UNCRPD. Article 12 of the UNCPRD refocuses legal capacity from whether tāngata whaiora can understand information, appreciate its consequences, and formulate a decision on their own, to a recognition that we all, regardless of ability, make decisions with help and guidance. So the relevant question becomes, 'is the person able to understand information, appreciate its consequences and formulate a decision alone or with support?' (Written submission, Academic)*

> *This capacity can be improved with active support to achieve each of the steps required, rather than passively observing whether the steps are achieved. (Written submission, Government agency)*

We also heard that it is important that mental health legislation explicitly acknowledges that mental unwellness does not equate to a lack of capacity. Mental capacity and legal capacity should not be conflated.

From some tāngata whaiora and family and whānau submissions we heard that the individual's level of insight and awareness of being unwell, alongside their ability to understand, were key considerations. Others considered the ability of tāngata whaiora to care for and manage themselves were relevant considerations.

Who should assess whether a person has decision-making capacity?

Across stakeholders we heard that capacity should not be solely determined by a clinician. Rather, capacity should be determined as a result of a holistic process that centres on the individual's capacity and draws on the perspectives of cultural advisors, cultural practitioners, kaimahi, clinicians, tohunga, legal experts, significant others and independent peer advocates who can support holistic decision-making around the needs of tāngata whaiora.

Notably, the inclusion of family, whānau and significant others was the most common response of written submissions to the question of who should assess whether a person has decision-making capacity. Just over a third stated the importance of this. The submissions recognised the importance of people who know tāngata whaiora being involved in the process, alongside mental health professionals.

Psychiatrists and psychologists were mostly identified as the professionals who should assess capacity, with the requirement of appropriate training and experience. A small number stated that assessment should be undertaken by other health professionals – for example, nurses or general practitioners. One social services professional body considered that social workers should undertake the assessment.

A mental health professional body stated that capacity is ideally conducted by a clinician with expert knowledge in the presenting condition of the tāngata whaiora. That submission identified the need for clinical skill and knowledge, “including a granular understanding of the factors that may affect the decision-making process”. Moreover, clinicians need to be culturally competent work with Māori and to understand the potential influence of te ao Māori on decision-making.

Another mental health professional body proposed that there should be provision for further assessment by a suitably qualified psychologist, in addition to an assessment by a psychiatrist where it was unclear if assessment criteria had been met – this reflected that capacity assessment “requires a complex understanding of cognition, motivation, mental health and behaviour” and the expertise of clinical psychologists in these fields.

SUPPORTED DECISION-MAKING

We heard a high degree of support for:

- supported decision-making to be a legislative requirement; and,
- the use of advance directives, as a mechanism of supported decision-making, to be embedded in the legislation.

A number of requirements were suggested in relation to the operationalisation of supported decision-making in legislation. Most significantly we heard that there would need to be options for the collective involvement of a range of key people in the decision-making processes: clinicians, family, whānau, significant others, community leaders, peer support workers, cultural advisers, independent peer advocates.

We heard that supports and processes, including independent whānau support, are required to facilitate the involvement of family, whānau and significant others and to ensure that they are appropriately communicated with and have access to full information necessary for informed decisions to be made.

In navigating the tension between the rights of tāngata whaiora and the needs of family and whānau, we heard that in situations where family and whānau have been excluded, provision should be made whereby clinical staff revisit the question of family and whānau engagement and involvement, while respecting the right of tāngata whaiora to reject such opportunities. We heard that such opportunities need to be revisited at regular intervals.

Similarly, an array of different requirements necessary to support advance directives were offered. Most significantly, there is a need for:

- the prioritisation of the development of a national system for storage of, and ease of access to, advance directives;
- appropriate processes, support and resources to support the effective implementation of advance directives as a legislative requirement;
- advance directives to be dated and regularly reviewed to ensure they are up to date, as the needs and wishes of tāngata whaiora can change over time;
- the individual's wishes, as set out in an advance directive, to be safeguarded.

A high degree of support was communicated by stakeholders in both consultation hui and written submissions, about the need and benefit of supported decision-making. Around a third of all written submissions across stakeholders favourably considered the role of supported decision-making.

Commentary centred on the valued role and significant potential of supported decision-making to:

- empower tāngata whaiora;
- ensure that the voice of tāngata whaiora is heard;
- enable the wishes, needs and perspectives of tāngata whaiora to be central to decision-making; and,
- demonstrate a commitment to Te Tiriti obligations, including tino rangatiratanga through empowerment and self-determination of tāngata whaiora Māori and their whānau, hapū, and Iwi.

From a small number of written submissions, mainly from tāngata whaiora and whānau, but also from across other stakeholders, we heard of the positive impact supported decision-making will have for population groups, if properly legislated, by empowering tāngata whaiora voice and choice and the upholding of rights. We heard of the important role of supported decision-making where the provision of informed consent is complicated, due to lack of capacity and the alignment of supported decision-making with Article 12 of UNCRPD.

In some consultation hui, the mental health sector participants considered that supported decision-making is difficult in acute situations because it is time and resource intensive. In addition, a lack of staff willingness and knowledge precludes the adoption of supported decision-making. Similarly, some family and whānau hui participants felt that clinicians are under resourced and, as a consequence, they felt that decisions about their loved one had been “bulldozed”.

Those with lived experience participating in the consultation hui were critical of the current Act because they consider that it privileges a western-biomedical model which positions psychiatry as the single and dominant authority. Those with lived experience who supported decision-making, shared that supported decision-making places the needs, perspectives and wishes of tāngata whaiora at the centre of health responsiveness. We note that some lived experience stakeholders referred to this as supporting a relational mental health system. We also heard from those with lived experience that this shift requires the provision of time to meet with the individual to discuss the individual’s needs and preferred treatment pathways.

We also heard that the work is currently being undertaken by the Law Commission to review the law in relation to adult decision-making capacity.

From across consultation hui and written submissions we heard that supported decision-making should be a legislative requirement and that legislation should address the following:

- supported decision-making requires a commitment on the part of the mental health system. In this regard, the mental health system needs to adapt and dedicate sufficient time for appropriate engagement with tāngata whaiora and their support people to discuss the individual’s needs and preferred treatment pathways;

- tāngata whaiora should have the right to include those most important to them in their decision-making and planning discussions;
- the inclusion of clinicians, whānau or significant others and independent peer advocates to provide a balance between clinical and lived experience knowledge. It was further suggested that kaumātua and kaiawhina, church and community leaders, cultural advisors, peer support workers and advocates be included to support tāngata whaiora and to ensure their full understanding and voice was at the centre. Some submissions referred to nominated support people and with individual submissions making reference to consideration of approaches followed in Victoria, Queensland and the United Kingdom;
- independent support for tāngata whaiora to provide the individual with protection. Multiple accounts were offered in consultation hui where tāngata whaiora had been asked to sign mental health documents without understanding what they were agreeing to. In this context, those with lived experience stressed the need for independent advocates and cultural support kaimahi to ensure tāngata whaiora understand what they are signing. It was further suggested that independent advocates and cultural support kaimahi should be empowered to intervene in the event that better explanations or an increased amount of time is required before the individual makes a written commitment.
- Both consultation hui and written submissions identified the independent (peer) advocate role as important to helping tāngata whaiora represent their views to clinicians and could also act as a safeguard where there are concerns that family or whānau are not representing the best interests of tāngata whaiora. To be binding and accessible, a small number of written submissions referred to the need for this role to be provided for in legislation and to be appropriately resourced, with appropriate training;
- a small number of written submissions referred to the need to clearly define the role of support people in legislation to set clear parameters, powers and limits;
- as previously discussed in relation to other aspects of the consultation, mental health legislation should acknowledge the wishes of tāngata whaiora about whether their family or whānau should be included. This was identified as important because it cannot be assumed that all tāngata whaiora have a positive or supportive relationship with the family or whānau. We also heard that mental health legislation should explicitly allow for significant others, as defined by tāngata whaiora, to be part of the decision-making process; and,
- information should be accessible and culturally appropriate, including translators, language support, and speech therapists, to ensure full understanding.

A small number of written submissions referred to different approaches to independent advocacy in other jurisdictions as potentially useful to consider in developing new legislation. These included professional advocacy services in Victoria, Australia, and in Sweden, the role of a legal mentor or personal ombudsman to assist people in making legal decisions.

We heard that caution over assuming a mental health professional is sufficiently trained, with understanding of holistic models of wellbeing, to be able to make a decision. In this context, we heard that any decision-making, where capacity has been determined to be compromised, should occur through collective decision-making, inclusive of wananga, that include mental health professionals, whānau and friends, and other supports such as peer support workers.

We also heard that advance directives are essential in these situations to ensure the individual's wishes are at the centre of decision-making.

Family and whānau

Within the context of supported decision-making we heard that family or whānau is essential. From family and whānau we heard that tāngata whaiora need to be regarded as part of a supportive network and that a holistic focus means that a collective notion of self needs to be included in mental health legislation. To this end, stakeholders emphasised the need for supports and processes to facilitate the involvement of family, whānau and significant others and to ensure that they are appropriately communicated with and have access to full information necessary for informed decisions to be made.

We also heard that the inclusion of family, whānau or significant others in decision-making needs to be explicitly included in new mental health legislation.

Supporting family, whānau and significant others to support tāngata whaiora

We heard that there is a need for support and education in order for family, whānau and significant others, identified by tāngata whaiora, to be able to support their loved one. We heard that family and whānau are often confused about their loved one's mental illness, the nature of their loved one's distress, treatment options and what it means to be placed under the Act. Within this context, we heard from whānau and family that mental health legislation needs to include provision for supportive education of family members. Such education needs to include supportive in-person encounters with mental health professionals. In accordance with tikanga Māori, we heard that collective supportive decision-making processes should be culturally appropriate and be centred around te ao Māori values and processes. We heard that manaaki should be extended to tāngata whaiora and their family, whānau and significant others to lay the foundation for an empowering process.

We heard from hui consultation participants that many family and whānau feel intimidated by mental health professionals and intimidation can create situations where families have been reluctant to question staff practices and decisions. We also heard that some family and whānau may be reluctant to assist with decision-making because of fear of reprisal: either a negative impact on tāngata whaiora or barriers being erected to exclude family and whānau from being able to support their loved one.

To help address the feelings of confusion, intimidation, and fear, we heard from family and whānau that there is a need for independent whānau support. We heard that legislation should provide for independent whānau advocates who would assist family and whānau to understand and navigate the mental health system, provide education relating to mental illness and the mental health system and advocate for family and whānau at times when they feel their voice has been compromised or where they feel their perspectives have not been adequately considered by mental health professionals. We heard that such provision would assist family, whānau and significant others to support tāngata whaiora in the decision-making process. There was also discussion about the need for separate advocates for whānau and tāngata whaiora so that both needs could be supported and met.

When family and whānau feel excluded

We heard competing perspectives on the rights of family and whānau to be involved in supporting tāngata whaiora decision-making. Some family and whānau asserted that it is their right to be involved, whether or not tāngata whaiora endorsed this involvement. In contrast, other family and whānau shared that their involvement should rest on the wishes of tāngata whaiora. We heard that the rights of tāngata whaiora to identify who they would like to support them should be included in mental health legislation.

Family and whānau shared considerable pain and frustration after having been excluded from the care and support of tāngata whaiora. We heard of families and whānau being prevented from visiting and supporting their loved ones while in acute settings, being excluded from the individual's treatment, as well as barriers they faced trying to access clinicians to discuss their loved one's needs, treatment and how they might support their loved one. From family and whānau we also heard that some clinicians had invoked the Privacy Act, in accordance with the wishes of tāngata whaiora, to effectively exclude family and whānau from engaging in the individual's treatment or in-person support.

The exclusion of family and whānau was described as a complex issue as it involves careful balancing of the wishes of tāngata whaiora and the needs and wishes of family and whānau.

We heard that the capacity of family and whānau to be involved in supported decision-making can vary enormously and there is a need to recognise that different family and whānau members may need to be involved at different times.

> *Recognising that whānau have different strengths and that different whānau may support the person at different stages of the care, assessment, treatment and support process according to their strengths. (Written submission, Person who works in a Kaupapa Māori organisation)*

Such flexibility is reflective of different strengths within the family unit. We also heard that it is important to ensure that family and whānau who are involved have the right motivation and insight and are acting in the best interests of the individual.

We heard some family and whānau were dissatisfied with their loved one's decision to exclude them from decision-making and support as they considered that the decision to exclude them was the result of the individual's unwellness. This created a high degree of frustration, confusion, and pain for family and whānau who wanted to support their loved one.

From other family and whānau we heard that it should be the decision of tāngata whaiora about who should be their support person(s) and who might have access to their personal information, including being permitted to discuss issues relating to tāngata whaiora with the clinical team. We heard that such decisions are based on the rights of the individual as well as an acknowledgement that some families and whānau are the source of the individual's "problems" and, in these situations, it was understood that the individual's wishes regarding their engagement with family and whānau need to be supported.

In navigating the tension between the rights of tāngata whaiora and the needs of family and whānau, we heard that in situations where family and whānau have been excluded, provision should be made whereby clinical staff revisit the question of family and whānau engagement and involvement, while respecting the right of tāngata whaiora to reject such opportunities. We heard that such opportunities need to be revisited at regular intervals.

Advance directives

Across stakeholders, we heard that the use of advance directives should be embedded in the legislation and that the use of advance directives provides tāngata whaiora with greater autonomy which is fundamental to a person's wellbeing. One submission described an advance directive document as a 'sacred taonga':

> *It holds the protections of the person and their values and preferences in it. It is their authority and holds their authorship. (Written submission, Tāngata whaiora)*

While the ability to create advance directives already exists, advance directives remain underutilised. Stakeholders suggested the following reasons for the lack of uptake of advance directives:

- clinicians failing to see the utility of the directives;
- a lack of knowledge amongst tāngata whaiora about their existence;
- a reticence amongst tāngata whaiora, informed by others' experiences of having had clinicians override the advance directive.

From those in the mental health sector we heard that advance directives remain underutilised because of a lack of an appropriate system to support them, such as flagging the advance directive's existence in an individual's file.

Stakeholders from both consultation hui and written submissions, considered that underutilisation could be addressed by giving advance directives legal status under new mental health legislation, and identifying the circumstances when advance directives are triggered.

We heard that legislation would need to provide maximum clarity on the legal effect of advance directives (and other supported decision-making tools). One submission from the academic sector included a soon to be published research article on the use of advance directives. This describes the legal effect as being on a spectrum where at one end advance directives could be binding on clinicians. At the other end of the spectrum, clinicians could be required to 'consider' or 'take into account' the advance directive. Intermediate positions could also be taken such as advance directive being binding only for refusals of certain forms of treatments, able to be overridden in certain circumstances (with a right of review or appeal), or given special force if completed in collaboration with their clinicians.

We heard that advance directives should be a legislative requirement. From a small number of stakeholders we heard of an array of different requirements necessary to support this to occur legislatively and in practice. We heard of the need for:

- a framework for creating valid advance directives and including clear identification of necessary legal requirements needing to be met, such as tāngata whaiora having the requisite capacity and being sufficiently informed about treatments that they may express views on, and not subject to undue influence.
- prioritising the development of a national system for storage of, and ease of access to, advance directives. Advance directives need to be prominently flagged to clinicians through IT systems and we heard that the creation of such a system should be included in mental health legislation.
- appropriate processes, support and resources to support the effective implementation of advance directives as a legislative requirement. This means that the development of an advance directive should centre on the needs and wishes of the tāngata whaiora and that the tāngata whaiora have the legislated right to develop an advance directive with a range of people who they trust and will assist tāngata whaiora to develop a directive that addresses their holistic needs, wishes and worldviews. This could include cultural advisors, clinicians, legal experts, significant others, whānau and family, and peer advocates.
- advance directives to be dated and regularly reviewed to ensure they are up to date, as the needs and wishes of tāngata whaiora can change over time.
- the individual’s wishes, as set out in an advance directive, need to be safeguarded. Consultation hui participants stressed that there should be no situation where a sufficiently resourced and holistically-informed advance directive can be overridden by a clinician. However, for the small number of written submissions responding to this question, most considered that instructions in an advance directive could be overridden either if -
- tāngata whaiora have or seemed to have been compromised, such as where the directive seems at odds with the individual’s known values, expectations and goals; it

was not in their best interests; and/or where tāngata whaiora had been subject to manipulation or abuse by supporting parties.
- in specific risk or harm-related situations where there is strong evidence of imminent threat to life or significant harm or where urgency is needed and implementing the directive would cause delay.

We also heard that advance directives should be used more broadly, including by those who are not under the Act – that it should become commonplace for all people using mental health services, reinforcing the need for people to be actively involved in treatment and care decisions. We heard that such provisions should be included in new mental health legislation. We heard the normalised use of advance directives would require a system change to ensure that these were easily accessible and created in partnership with tāngata whaiora, whānau or significant others, cultural advisors, support people and the clinical team. Education and training would be required.

When there is no advance directive

In situations when there is no advance directive, we heard that legislation should require clinicians to enlist the perspectives of the individual's family, whānau or significant others as soon as practically possible.

In addition, in the absence of an advance directive, independent advocates should be enlisted to ensure the needs of tāngata whaiora are addressed. We heard that independent advocates, in these situations, are essential as it cannot be assumed that the enlistment of family and whānau would be in the interests of tāngata whaiora.

We heard repeatedly that if a person is placed under the Act, best efforts should be made to draft an advance directive before discharge. There is opportunity for advance directives to be developed as part of a routine admission process to secondary services and as a part of primary care.

Supported decision-for children and young people

A small number of written submissions responded to the consultation question about what supported decision-making should look like for children and young people. Most were submissions from tāngata whaiora, whānau, and people working in health or social services providers. The submissions mainly identified the importance of the child/ young person being empowered through their choice of support people and appropriate information provision. This included:

- the child/ young person being fully informed including about their rights, and relevant care and treatment options so that decisions can be based on full information. This requires the opportunity and space for the child/ young person to ask questions and to have these answered in age-appropriate and effective ways;

- all information needs to be presented to children and young people in culturally and developmentally suitable ways;
- the involvement of trusted support people chosen by the child/ young person; and
- the voice of the child/ young person being fully expressed, listened to, and respected.

Some of these submissions also specified the need for parents, family, whānau, guardians, and carers to have full information and involvement.

Supported decision-making for disabled people

A small number of written submissions responded to the consultation question about requirements that should be included in the legislation regarding disabled people. Mostly submissions were from tāngata whaiora, whānau and mental health professional bodies.

While a range of views and commentary were provided, themes that emerged centred on the rights of the individual, the provision of information, environmental considerations, and the need to ensure practice is devoid of discrimination. Specific commentary included that:

- the voice and viewpoints of the disabled person should always be heard and be at the centre of all decisions;
- supported decision-making can play an important part to ensure disabled people have the necessary support to exercise legal capacity;
- there should be access to information and materials in multiple formats (e.g. text-to-speech). Information should be provided in New Zealand Sign Language and appropriate forms of communication, for example for people who are autistic or non-verbal). Material needs to be easy to understand (including about medication);
- facilities need to appropriately address the needs of disabled people. There is a currently a lack of insight into the adverse effects of clinical environments. Examples include autistic people being forced to stay in unfamiliar, harmful environments and without access to staff knowledgeable in how to appropriately respond to different needs (such as understanding responses that calm rather than trigger adverse behaviours) and being disallowed access to available calming spaces when need is self-identified. It is important that new legislation prevents this.

> *Many Autistic people have been refused the sensory/calming room when they have asked, then they meltdown which then has the staff jumping on them… when we ask to go to the room, we are letting you know, "Hey I am having a hard time, I need to desensitise". Staff should not refuse this. (Written submission, Tāngata whaiora)*

- the legislation should address stigma and discrimination. The rights of disabled people must be upheld. There must be freedom from discrimination;
- there should be special protections, including more family and whānau support and involvement, and access to additional independent professional support; and,
- new legislation should explicitly consider the specific needs related to different disabilities.

RESTRICTIVE PRACTICES

We heard that Aotearoa New Zealand's current focus is on crisis intervention and that the use of restrictive practices would greatly reduce with an increased focus on community-based comprehensive and preventative health care, including mental health.

Stakeholders had divergent views over whether restrictive practices should be allowed:

- lived experience, Māori health sector consultation participants and family and whānau shared that the use of restrictive practices are almost always unnecessary in inpatient settings;
- mental health sector consultation hui unanimously suggested that restraint and seclusion are necessary in some situations and the elimination of seclusion and restraints would prevent clinicians from keeping the individual, other tāngata whaiora and staff safe. In this regard, we heard the potential use of restraint as an option needs to exist in legislation;
- the majority of written submissions considered that some form of restrictive practice should be allowed (including some, and mostly tāngata whaiora, that referred specifically to allowing seclusion), but with many, including tāngata whaiora and whānau, stating the need for limits to be prescribed around use; and,
- notably a small number of written submissions indicated that no restrictive practices should be allowed. Of interest, approximately half of the submissions from kaupapa Māori, government and mental health professional bodies that commented on the use of restrictive practices, submitted that the practice of seclusion should be banned.

The elimination of seclusion was strongly proposed by consultation hui participants.

Mental health legislation and restrictive practices

In the main, stakeholders agreed the legislation should address the following areas.

Definitions

- There needs to be clear definitions of seclusion (and use of other restrictive practices). It was felt that vague definitions have enabled seclusion to be used in a way that is inconsistent with clinical or practice definitions of what seclusion entails.

Limitations

- Circumstances allowing the use of restrictive practices need to be tightly prescribed;
- Restrictive practices should only be used as a last resort and when all other appropriate options have been exhausted;
- "Last resort" should be clearly defined in mental health legislation;
- The use of restrictive practices should be time limited. They should only be used in situations of immediate danger, harm, and violence;

- Individuals should be free from restraint as soon as they are no longer actively attempting to hurt themselves or others; and,
- Decisions around seclusion, restraint and sedation should be informed by an individual's advance directive.

Reducing restrictive practices

Across stakeholders we heard that the need for restrictive practices would be greatly reduced through:

- the incorporation of practices reflective of mātauranga Māori whereby the mana of tāngata whaiora are central to service provision;
- person-centred practices prevent the escalation of emotions, tensions and situations that lead to the point of intervening with seclusion or restraints;
- ensuring acute inpatient environments are designed to facilitate the individual's healing;
- adequately resourced workforce, appropriate staff training and development.

Exclusions

- there was strong support from consultation hui stakeholders, and some submitter stakeholders (kaupapa Māori, government, and mental health professional bodies) for new legislation to eliminate seclusion;
- if legislation does ban seclusion, it also needs to expressly prohibit the use of chemical sedation as stakeholders were concerned that chemical sedation would be relied on as a substituted response; and,
- restrictive practices should not be used on children, young people, disabled people, and those who are suicidal.

Workforce standards

- legislation should require all staff to be trained in de-escalation skills, effective engagement practices, and trauma-informed practice as well as being supported to use these skills. Only those with such competencies should be permitted to use restrictive practices;
- organisations should ensure staff have a shared understanding about the use of restrictive practices and the consistent use of risk assessment tools
- there must be clear and consistent requirements and guidance defining the use of restrictive practices; and,
- legislation should require staff to undertake cultural competency training, including training to support an understanding cultural safety and the elimination of racism.

Monitoring and review

We heard that legislation should:

- embed safeguards where onus is placed on mental health professionals to demonstrate the need for the use of the restrictive practice;
- require mental health professionals to evidence that efforts to de-escalate have been attempted before seclusion or restraint can be exercised;
- protect tāngata whaiora by requiring the reporting of restrictive practices to an independent review body. Such reporting should include -
- the use and type of restrictive practice used;
- duration of the restrictive practice; and,
- clinical justification for the use of restrictive practice;
- require any restrictive practice event to be reviewed “quickly” and that such reviews should involve independent peer support advocates and family, whānau or significant others as part of the review process; and,
- require extensive internal and independent review practices as a legislative requirement.

Stakeholders shared often greatly divergent opinions on the use of restrictive practices and their role, if any, in future mental health legislation. Such differing views is understandable given the complexities associated with restrictive practices. Notably, however, there was consensus that there is need to change the way in which restrictive practices are used.

Some stakeholders considered that restrictive practices are being used to coerce people whereby the individual is threatened with being placed under the Mental Health Act or seclusion.

From family and whānau and those with lived experience we heard that restrictive practices are ‘draconian’, ‘degrading’, ‘barbaric’ and ‘akin to torture’. We heard that restrictive practices have been misused and have retraumatised tāngata whaiora. We also heard concern that restrictive practices create an environment of fear, intimidation and forced compliance.

Stories of pain and ongoing trauma as a result of restrictive practices were shared. We heard descriptions of what seclusion and other restrictive practices would be like for people with different disabilities, for example neurodiversity.

Those with lived experience shared how restrictive practices have been used as a preventative de-escalation practice and to require compliance and conformity – to manage behaviour rather than safety. We heard examples where the harmful impact of restrictive practices have caused tāngata whaiora to avoid future engagement in medical care, including health screening programmes. In this regard we heard that legislation should explicitly prohibit the preventative use of restrictive practices.

From Māori in the mental health sector, we heard that restrictive practices are punitive and commonly result in tāngata whaiora and their whānau being traumatised. We also heard that restrictive practices damage the relationship between tāngata whaiora and mental health staff.

Perspectives on the reduction or elimination of restrictive practices

The majority of consultation hui stakeholders shared that the use of restrictive practices are almost always unnecessary in inpatient settings. We heard that the current focus in Aotearoa New Zealand is on crisis intervention and that the use of restrictive practices would greatly reduce with an increased focus on community-based comprehensive and preventative health care, including mental health.

Participants from the mental health sector consultation hui supported the reduction of the use of restraint and seclusion but suggested that some forms of restrictive practice are necessary. It was considered that the elimination of restraint would prevent clinicians from keeping the individual, other tāngata whaiora, and staff safe.

Approximately 40 per cent of the written submissions responded to the consultation question about what if any restrictive practices should be allowed. Of these, most considered that some form of restrictive practice should be allowed (including some, and mostly tāngata whaiora, that referred specifically to allowing seclusion), but with many, including tāngata whaiora and whānau, stating the need for limits to be prescribed around use. Similar to mental health sector participants, the common concern expressed was the need to protect staff and tāngata whaiora from violence and harm.

A small number of written submissions indicated that no restrictive practices should be allowed. It is noteworthy that around half or more of the submissions from kaupapa Māori, government and mental health professional bodies commenting on the use of restrictive practices, submitted that seclusion should be eliminated.

In reference to seclusion, across consultation hui stakeholders we heard a high degree of support for the elimination of seclusion. Included in these views was the need for government to issue a clear timeline for its elimination, particularly given this has been on the government agenda for years. Support for the elimination of seclusion was evidenced in stakeholders offering multiple examples where zero seclusion practices have operated successfully in Aotearoa New Zealand. These examples were shared to reinforce the need for mental health legislation to explicitly exclude seclusion as a practice and to instead place emphasis on processes that avoided the need for seclusion, including the use of de-escalation and modifications to the environment.

In reference to restraint, we heard from consultation hui participants that new mental health legislation should actively exclude the use of mechanical restraints. However, we heard some limited support for the provision of the individual being physically restrained in specific situations where the individual might be actively trying to hurt themselves or someone else. This distinction between mechanical and physical and manual restraint was not so apparent from the written submissions.

It is noteworthy that the few family and whānau consultation hui participants who supported the rare use of mechanical restraints cited a degree of scepticism around the extent to which poor clinical practices and management have contributed to the perceived need for restraint to be enacted.

All stakeholders engaged in the consultation hui, and many of the written submissions, agreed that the use of restrictive practices should be tightly prescribed and only be used as a last resort when all other appropriate options have been exhausted, and that this should be clearly defined in mental health legislation.

Across stakeholders, we heard that the process of seclusion and restraint should be time limited and only used in situations of immediate danger, harm, and violence. We also heard that legislation should explicitly state that the individual should be free from restraint as soon as they are no longer actively attempting to hurt themselves or another.

A small number of written submissions stated that restrictive practices should not be allowed in respect of children, young people, disabled people, and those who were suicidal.

Defining restrictive practices and safeguards

Caution over definitions of seclusion, and other relevant terminology was shared across stakeholders. We heard that mental health legislation must clearly define seclusion, and it was felt that vague definitions have enabled seclusion to be used in a way that is inconsistent with clinical or practice definitions of what seclusion entails. In this regard, some shared their view that restrictive practices have "operated by stealth" within acute mental health wards whereby the use of chemical restraint has operated "under the radar". We therefore heard concern that the removal of seclusion and physical restraint could result in the increased use of chemical restraint, and some considered that legislation could prevent this by expressly prohibiting the use of chemical restraint.

We heard too that there are other practices that should be considered "restrictive", and these practices need active consideration. Such practices include locked rooms or wards, intimidation to confine a person to a particular space, and restricted access to phones and water.

Mātauranga Māori

We heard a great deal of support for the incorporation of practices reflective of mātauranga Māori. Māori working in the mental health sector furthered that restrictive practices would not be necessary if the mana of tāngata whaiora was central to service provision. We further heard that mana enhancing practices would centre on staff appropriately engaging tāngata whaiora and their whānau as well as the prioritisation of de-escalation practices, which would mitigate the need to rely on restrictive practices. This theme was also prevalent in submissions from non-Māori stakeholders across consultation hui and written submissions.

Within acute mental health inpatient facilities, we heard person-centred practices can prevent the escalation of emotions, tensions and situations that lead to the point of intervening with seclusion or restraints. We heard of the importance of de-escalation approaches, but that staff often lack sufficient skills to engage in de-escalation – this is discussed below in relation to workforce needs (see 11.5).

Additionally, Māori health sector consultation hui participants considered that restrictive practices are often unnecessary in inpatient settings. They referenced that the unnecessary nature of restrictive practices was evidenced in the effectiveness of kaupapa Māori services responding to the needs of tāngata whaiora. Notably, they emphasised that drawing on the values and practices embedded within te ao Māori would remove the need for restrictive practices.

From multiple stakeholders across consultation hui and written submissions, we heard that appropriate engagement with tāngata whaiora and whānau is essential to a model of care reflective of mana enhancing practices. We heard appropriate mana enhancing engagement practices are vital, including when an individual first arrives at an acute mental health facility, and guidelines surrounding engagement should be included in the new legislation specifying the steps that must be taken when an individual is admitted to an acute mental health care facility.

We heard that kaupapa Māori approaches, including the incorporation of traditional healing practices, would enhance an individual’s mana and assist with their healing, and would reduce the need for restrictive practices.

Further, we heard that the acute mental health environments could be better designed to incorporate physical aspects of te ao Māori, be welcoming and accessible to family, whānau and friends, and support the connection of tāngata whaiora to readily available cultural support staff and kaumatua.

We also heard from Māori working in the mental health sector that legislation should require organisations to engage in restorative processes, post the restrictive practice activity, with tāngata whaiora who have experienced restrictive practices. The spirit underlying such practice is to assist tāngata whaiora to address possible trauma arising from experiencing restrictive practices and to work in together to develop a strategy to avoid using such practices in the future. This would also provide the opportunity to restore the relationship with staff.

Advance directives

We heard from the mental health sector that advance directives should be foundational to an individual’s treatment plan and that decisions around seclusion, restraint and sedation should be informed by an individual’s advance directive.

We also heard, however, that seclusion and restraint could remain a challenge in situations where an individual does not have an advance directive, for example, this would likely be the case for those presenting in an acute unwell state for the first time.

Environmental and workforce considerations

Across stakeholders we heard that restrictive practices would be greatly reduced if a number of environmental, workforce, and infrastructure considerations were appropriately addressed. In turn this would also improve the overall safety of staff and tāngata whaiora.

> *Safe and supportive environments are needed to be able to care for people and protect their and others safety, including staff safety. However… under-resourced specialist mental health services and current facilities, that are not purpose-built, mean that we often lack the ability to achieve best outcomes, which carries the risk to staff and patient safety. (Written submission, Clinical mental health professional body)*

We heard that acute inpatient environments can exacerbate an individual's distress and prevent healing. Facilities have also not been purpose-built to optimise safety.

> *There are significant needs to ensure physical and environmental safety for all involved, but our current inpatient units do not meet these. They are not conducive to the healing process or the need for whānau to rest and recover in their own time. They remain heavily institutionalised and stigmatised and wider hospital settings contribute to this. In addition, whānau Māori are also highly pathologised and this leads to increased restrictive practices being used when working with Māori due to the poor access whānau have to Māori specific healing environments. (Written submission, Clinical kaupapa Māori body)*

Family and whānau considered that as compulsory treatment is inherently restrictive, as it removes the rights of tāngata whaiora, it creates an environment that enables the use the restrictive practices.

Across consultation hui and written submissions the need for better resourced workforce, appropriate staff training and development and different physical and care environments was identified.

Stakeholders felt that restrictive practices are relied on because of inadequate staffing. We also heard that such use is more likely to occur outside of regular working hours and in weekends when it is more difficult to access peer and cultural supports. We heard that new mental health legislation should provide for adequate staffing, peer and cultural support outside of regular working hours.

> *I fully support a zero-seclusion approach; however this will require significant resourcing to grow and turn around a burnt-out and understaffed work force. (Written submission, Individual, Person who works in mental health services)*

We heard that a lack of de-escalation skills amongst staff can exacerbate someone's distress. As a minimum and mandatory requirement, we heard that mental health legislation should require all staff to be trained in de-escalation skills, effective engagement practices, and trauma-informed practice as well as being supported to use these skills. Only those with demonstrated competencies of the above should be permitted to use restrictive practices.

We also heard that all staff should have a thorough grounding in when to use restrictive practices. Organisations should ensure staff have a shared understanding about the use of restrictive practices and that there is consistent use of risk assessment tools. There must be clear and consistent requirements as well as guidance defining the use of restrictive practices. We also heard that the use of restrictive practices-should be monitored, as discussed later in this section.

Cultural competency training, including understanding cultural safety and the elimination of racism, should also be required. We heard that the presence of peer support and cultural workers in inpatient units have resulted in a reduction in the use of restrictive practices as these workers have been able to de-escalate situations without the need for seclusion. We heard that legislation should include the requirement for peer and cultural workers as integral members of acute mental health facilities.

Acute mental distress and substance use

Across stakeholders there was a degree of uncertainty about the ability to reduce the use of restrictive practices for those experiencing acute mental distress alongside substance use, namely they were unsure of how to minimise trauma while protecting the individual. We heard of the consideration that must be given to the context and different environments in which restrictive practices are used.

> *Evidence demonstrates that patients who are intoxicated with alcohol or other drugs are less likely respond to verbal forms of de-escalation and are more likely to require acute sedation compared to patients with a principal diagnosis of mental illness… Other research has also confirmed that methamphetamine use is frequently associated with aggression towards staff and other patients, and the need for restrictive practices. (Written submission, Health professional body)*

In particular the issue of managing drug induced psychoses was a raised as a key issue. From the small number of stakeholders who commented on this issue, there were different views about whether such contexts required the retention of restrictive practices.

One submission referred to the in-development Ministry of Health / Health Quality and Safety Commission guidelines to support the safe management of acutely agitated or aggressive individuals in the absence of seclusion, which could be used to inform service development.

Monitoring and review

Stakeholders considered an insufficient level of oversight and accountability has enabled the current level of restrictive practice use and there is a need for very tight monitoring and regulation, including the recording and reporting of restrictive practice-related information.

Across stakeholders we heard that safeguards should be embedded in legislation. Safeguards proposed included:

- an onus on mental health professionals to demonstrate the need for the use of the restrictive practice;
- a requirement for mental health professionals to evidence that efforts to de-escalate have been attempted before seclusion or restraint can be exercised; and,
- a requirement to report incidents where restrictive practices have been used.

It was considered that these requirements would safeguard against the overuse of restrictive practices and would reinforce the use of seclusion and restraint as a last resort.

We also heard that legislation should protect tāngata whaiora by requiring the reporting of restrictive practices to an independent review body. Such reporting should include:

- the use and type of restrictive practice used;
- duration of the restrictive practice; and,
- clinical justification for the use of restrictive practice.

We heard that legislation should require any restrictive practice event to be reviewed “quickly” and that such reviews should involve independent peer support advocates and family, whānau or significant others as part of the review process.

From different stakeholders we heard that that the legislation should require the use of restrictive practices to be extensively internally and independently reviewed.

The following proposals for monitoring and review have come from different stakeholder submissions who shared a variety of views about what monitoring and review could look like in practice. They are premised on the need for transparency and stringent accountability, and are intended to significantly reduce and eliminate the use of restrictive practices, including racist and inequitable use:

- investigate the use of each restrictive practice event to assess why other steps failed and to determine whether the use was appropriate and necessary;
- require a debriefing after every event, including with staff, tāngata whaiora, peers, family and whānau. Require reporting of the event family and whānau (with the permission of the tāngata whaiora);
- require an external review (possibly by a review panel) of every use, involving all parties, family and whānau, and representation from Iwi and people with lived experience;

- quarterly audits of events undertaken by lived experience, whānau and cultural experts;
- reviews of each event should explicitly examine racial and gender bias and what service and practice improvements and resources are needed to address issues identified;
- patterns of concerning use should lead to an urgent review and the implementation of immediate training and safety plans.
- require hospitals to report on the use of restrictive practices in the emergency department and to include information on the “level of access block” and overcrowding in the emergency department at the time restrictive practices were used;
- the establishment of an audit agency to monitor and investigate use of restrictive practices (including where there has been raised use of individual’s medication and dosage);
- close monitoring through, for example, an open national database with mechanisms for robust monitoring. Data disaggregated by use of different restrictive practices according to age, gender, and ethnicity. National reporting of all events;
- measures implemented to address disproportionate use of seclusion and restraint on Māori and Pasifika tāngata whaiora;
- national monitoring, reporting, and review of restrictive practices to be co-designed and aligned with the Health Quality and Safety Commission National Events Reporting Policy with a view to minimising and eliminating restrictive practices; and
- national guidelines to support consistent data reporting across hospitals and services, by demographics, and restrictive practice usage – for example types of restraints used, numbers restrained, number of times individuals are restrained, length of use.

PROTECTING AND MONITORING PEOPLE’S RIGHTS

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

A diverse range of different responses were offered. The most common response was that it should be a judge or the court who should be responsible.

Notably however, some consultation hui participants stated that the environment of current Mental Health Act courts is not conducive to a sense of wellbeing, especially for tāngata whaiora. As such, there was a call for a more informal process and potential environments like marae or community environments.

The process for approving the use of compulsory mental health treatment

There was strong support for a process that relied on a human rights framework and acknowledged the need to appropriately reflect te ao Māori worldviews. In particular a collective notion of self needs to be included in the approval process to reflect family and whānau as an essential component of engagement, decision-making, advocacy and support.

Supports to make it easier to engage in the process

The following suggestions were shared to ensure tāngata whaiora can be better supported to engage in processes to approve compulsory mental health treatment:

- ensuring tāngata whaiora and significant others are informed and understand key information including their rights and the processes under the legislation;
- including cultural, independent peer support and advocacy;
- including whānau need to be included in the decisions about compulsion, care, treatment and support of tāngata whaiora;
- ensuring workforce and accountability surrounding cultural competency as a prerequisite for working with Māori.

Onus on clinicians to demonstrate the rights of tāngata whaiora are upheld

The onus should be placed on those invoking mental health legislation to demonstrate the individual’s rights are being upheld. This protection should be included in new mental health legislation.

Challenging clinical decisions

We heard tāngata whaiora need to be supported in their right to disagree and appeal clinical decisions and must have the right to:

- choose and refuse treatment, revoke consent, make their own choices;
- legal advice and representation;
- advocacy and support;

- have all alternative treatment options explored, with support from their clinician;
- independent review, monitoring and investigation;
- have their requests for alternative treatment options monitored, independently reviewed, and with proactive intervention when the individual's rights and wellbeing are compromised; and,
- seek recourse from an independent body, such as a court, tribunal or independent monitoring body.

An independent body to investigate complaints, monitor and review practice

We heard a great deal of support for the creation of independence surrounding the review of complaints and independent monitoring.

We heard strongly of the need for an independent complaints body.

We heard there is a need to for an independent monitoring body to:

- ensure greater oversight over treatment decisions, processes, services (as experienced by tāngata whaiora) and the effectiveness of the individual's treatment;
- independently monitor the use of compulsory treatment and restrictive practices including psychological, cultural, lived experience and whānau perspectives; and,
- monitor treatment options to ensure these are culturally appropriate, mana enhancing and include appropriate cultural involvement, including cultural advocates, kaumātua, has occurred in assessment and reviews.

We heard that such independent body/ bodies should have the following powers and responsibilities:

- constant and proactive monitoring, empowered to make unannounced visits to mental health care facilities;
- inspect, investigate, reach findings;
- require substantive actions to address findings;
- review and overturn, discharge a compulsory order; and,
- hold clinicians and mental health treatment facilities to account by issuing penalties and sanctions.

Across stakeholders, we heard concern that the Mental Health Act has resulted in the continued erosion of the rights of those who have been placed under the Act. We further heard that those placed under the Act have no significant or efficient recourse and current provisions were described as ineffective in light of their lack of independence.

Who should be responsible?

People were asked who they believed should be responsible for approving the use of compulsory mental health treatment.

Written submitters were invited to respond to a question of who should be responsible for approving the use of compulsory mental health treatment. The majority of submitters did not respond to this question, however, of those who responded a diverse range of different individual response options were elicited. While there was no consensus across submitters the most common response was that it should be a judge or the court who should be responsible, with a small number specifying that the decision should fall under the jurisdiction of the Family Court. The justification is that the justice system provides accountability, legality, and protection, and that the Family Court meets accountability requirements while providing a more informal and accessible environment when compared to other courts.

A small number thought the use of the District Court or a tribunal would have a negative effect on population groups as it would put people who are already marginalised at a disadvantage and thereby exacerbate racism, bias, discrimination, and inequities in compulsion. It was thought that this would also perpetuate an unjust overreliance on settings that favoured clinical opinions and western approaches.

From some consultation hui participants there was feedback that the environment of current Mental Health Act courts is not conducive to a sense of wellbeing especially for tāngata whaiora who were required to go back to the inpatient unit, even though they had the support of peer workers or family and whānau. There was a call for a more informal process and potential environments like marae or community environments.

The process for approving the use of compulsory mental health treatment

Approximately one third of written submissions, from across stakeholders, responded to the consultation question about what the approval process should be for compulsory mental health treatment.

Responses reflected a strong adherence to human rights, person-centred and mana enhancing practices and identified a range of different considerations relevant to this focus. These included the importance of processes that ensure:

- tāngata whaiora understand their rights, inclusive to full informed consent;
- tāngata whaiora are supported and represented;
- improved support and representation including free legal representation, legal aid, advocacy, fulltime advocates, peer support;
- cultural support for the individual (and whānau) throughout all processes including as a standardised part of clinical reviews, and including language support;
- a holistic collaborative assessment and decision-making process that draws on the perspectives of cultural advisors, cultural practitioners, kaimahi, clinicians, legal experts, significant others and independent peer advocates to afford holistic decision-making around the needs of tāngata whaiora; and,
- that there should be no indefinite treatment orders.

From consultation hui participants we heard that it is essential that the approval process appropriately reflects te ao Māori worldviews. From Māori and Pasifika we heard that such a holistic focus means that a collective notion of self needs to be included in the approval process to reflect family and whānau as an essential component of engagement, decision-making, advocacy and support.

We also heard that there should be collective decision-making, supported by independent advocates with expertise in healthcare system and versed in te ao Māori. We heard that these advocates would be essential to assisting tāngata whaiora and their whānau bridge the space between practitioners, tāngata whaiora and their whānau in culturally appropriate ways.

Information required for requests to use compulsory treatment

Written submitters were invited to respond to a question about what information should be required for requests to approve the use of mental health treatment.

The majority of written submissions did not respond to this question. For the small number that did, required suggested information included:

- evidence of the assessment, and the outcomes of assessment and to demonstrate that the criteria for compulsory treatment has been reached;
- cultural assessments and how these have been given effect;
- the contribution to assessment by cultural advisors, cultural practitioners, clinicians, legal experts, significant others and independent peer / advocates;
- advance directives and how these have been respected and used;
- evidence and outcomes of capacity assessment, inclusive of cultural advisors, cultural practitioners, clinicians, legal experts, significant others and independent peer advocate perspectives;
- history of past assessment and treatment and what has and has not been successful.

Making it easier to engage in the process

Across the written submissions and consultation hui we heard of different ways in which tāngata whaiora (and family and whānau) could be better supported to engage in processes to approve compulsory mental health treatment. The core themes that emerged from the consultation process are discussed below. They relate to cultural, peer-support and advocacy, the centrality of whānau, fully informed decision-making, and workforce accountabilities.

Ensuring tāngata whaiora and significant others are informed and understand

From those with lived experience, we heard about a high degree of confusion when they were placed under the Act and that they did not know what their rights were. As a consequence, there were many accounts of feeling confused, powerless, and traumatised.

We heard that tāngata whaiora have the right to be fully informed and that this right, and specified processes of communicating this right, should be included in new mental health legislation.

This feeling of confusion also extended to significant others, and family and whānau, who identified often feeling confused about the Mental Health Act and were often not aware of their rights or the rights of tāngata whaiora.

We equally heard that acknowledging the centrality of whānau requires provision for culturally appropriate engagement practices, education regarding mental health, and mental health legislation to ensure that tāngata whaiora and family and whānau are informed and equipped to make supported decisions. We heard that family, whānau and significant others have the right to be better informed and that this right and the right to have information provided in an easily understood manner should be included in mental health legislation.

We heard that information needs to be appropriately communicated to tāngata whaiora, family and whānau, including:

- the provision of information in a way that is consistent with cultural, religious, linguistic, and disability-related needs;
- information, including the process, rights and needs, being provided in different languages and mediums, and accessible formats; and,
- information that needs to be proactively provided at the outset, is easy to access, understand and engage with – including the removal of technical jargon and medical terminology.

> *Asian peoples commonly encounter language and cultural barriers to appropriate mental health healthcare. Many New Zealand mental health professionals cannot effectively communicate with or provide culturally relevant care for Asian and ethnic minority groups. (Written submission, Organisation representing the needs of Asian people)*

Cultural, peer support and advocacy

We heard that the wellbeing of tāngata whaiora can be protected by ensuring their wishes, needs and perspectives are the central consideration. To this end, feedback emphasised that the support of cultural advisors, cultural practitioners, legal experts, significant others and independent peer advocates would provide tāngata whaiora a level of protection. As stated above, tāngata whaiora should also have accessible legal advice and representation.

We heard that there should be support and advocacy in every facility and such support should be readily accessible to tāngata whaiora.

A common theme from those with lived experience was the importance of independent peer advocates and that advocacy should be provided from the point of crisis through to care. We heard that this protection should be included in new mental health legislation.

> *I think what would really help in the future with the Mental Health Act is for someone like me who is distressed to be able to have somebody to walk alongside me as I'm going through any kind of process. Somebody who's been through the system… Somebody who understands and somebody who's able to navigate that system with me. A peer support worker is what I would like. (Written submission, Tāngata whaiora included in a mental health professional body)*

Those with lived experience considered that independent peer advocates:

- are needed as a conduit between tāngata whaiora and health staff. This would involve assisting in the communication between tāngata whaiora and health staff, to advocate for the needs and rights of tāngata whaiora while effectively preventing the development of poor relationships between tāngata whaiora and health staff; what we heard referred to as "hostility"; and
- should be funded, made universally available and embedded within new mental health legislation.

Family and whānau participants spoke of the power imbalances that privilege clinicians which can impact on the wellbeing of tāngata whaiora and that of family, whānau and significant others. These imbalances reportedly result in a sense of confusion, intimidation and fear. Within this context, we heard that mental health legislation should include the requirement for independent family and whānau advocates who would support family, whānau and significant others when:

- they feel their voice has been compromised
- mental health professionals do not appear to be adequately including their perspectives;
- family, whānau and significant others need assistance in their support of tāngata whaiora; this was especially noted in relation to supported decision-making processes.

We also heard that such independent advocates should be made available seven days a week and after hours.

Centrality of whānau

Across stakeholders the role of whānau was highlighted as pivotal to supporting tāngata whaiora and we heard that mental health legislation needs to:

- explicitly state that whānau need to be included in decisions about compulsion, care, treatment and support of tāngata whaiora;
- set out the rights of whānau;
- include significant others, as identified by tāngata whaiora, as an integral component of the individual's wellbeing and treatment; and,

- require sufficient time and a process appropriate to whānau to help family and whānau to fully be part of the process and to be fully informed.

Workforce and accountability

From consultation hui and the voices of Māori working in the mental health sector we heard repeated concern about the inherent biases of mental health professionals that have disproportionately disadvantaged Māori through use of the Mental Health Act. Stakeholders considered that the disproportionate representation of Māori being placed under the Mental Health Act has occurred as a result of racism and discrimination. They outlined that this is reflected in the disproportionate readiness to place Māori under the Mental Health Act as well as Māori being placed under the Act for longer periods of time than non-Māori.

We heard that the mental health workforce holds a pivotal role in improving the wellbeing of tāngata whaiora. As such, stakeholders suggested that new legislation should embed requirements for the mental health workforce to demonstrate cultural competency as a prerequisite for working with Māori. We further heard that mental health legislation needs to include mechanisms for monitoring workforce performance and accountability when practitioners fail to adhere to a defined standard. Notably, we heard from consultation hui stakeholders that the role of district inspectors is not appropriate in this arena because of a lack of perceived independence.

Onus on clinicians

Through consultation hui, participants with lived experience considered that the Mental Health Act has been misused by mental health practitioners and this had resulted in significant levels of trauma. To provide one level of protection, stakeholders outlined that legislation should place an onus on those applying mental health legislation to demonstrate that an individual's rights are being upheld.

Challenging clinical decisions

Written submissions invited feedback on the process that should be used when a person disagrees with the compulsory mental health treatment chosen for them by a health practitioner. There were a small number of responses provided, with the majority from tāngata whaiora and family and whānau.

Contextually, some tāngata whaiora submissions described the difficulties of challenging clinical decisions, so much so that it is futile as they "are up against the system". Tāngata whaiora shared experiences of having their concerns and complaints ignored. From the mental health sector we received submissions that existing legislation is insufficient in meeting the needs of tāngata whaiora:

> *The current Section 16 process (court review of clinician decisions) is awful, never succeeds. It raises false hope then causes distress and puts individuals and clinicians*

> *in adversarial positions. (Written submission, Person working in mental health services)*

We heard of continued disempowerment whereby tāngata whaiora and family and whānau shared accounts of tāngata whaiora being required to continue with medications that they did not feel were working, including where the individual was deemed 'treatment resistant' and without the exploration of alternative options. We heard that tāngata whaiora can be labelled as 'non-compliant' if they do not wish to take the required medications. Similarly, experiences were shared of medication being used to sedate and "manage" rather than for treatment. The following insights came from a written submission made by a mental health professional body, which set out direct quotes from tāngata whaiora:

> *Tāngata whaiora felt services place too much emphasis on medication. They felt the default option was heavy medicalisation unless whai ora 'speak up' and advocate for themselves and with little review or scrutiny. (Written submission, Tāngata whaiora)*
>
> *Putting people on medication and never reviewing it…unless you have a little bit of knowledge or understanding, or you dare to speak up… (Written submission, Tāngata whaiora)*
>
> *The medication absolutely annihilated me.. It did something to me that changed my life… they call it a chemical lobotomy, and I wouldn't wish it on my worst enemy… my energy levels dropped to 10 percent. (Written submission, Tāngata whaiora)*
>
> *It's horrible. You're on so much medication and you wake up and your pillow is completely soaked. (Written submission, Tāngata whaiora)*

Within this context the importance of a person-centred and mana enhancing approach was put forward.

We heard that tāngata whaiora need to be supported in their right to disagree and appeal clinical decisions.

We additionally heard that mental health legislation should specify that tāngata whaiora have the right to:

- choose and refuse treatment, revoke consent, make their own choices;
- legal advice and representation - the provision of free legal advice and representation;
- advocacy and support – the provision of an independent advocate chosen by the tāngata whaiora or in collaboration with the individual's family, whānau or significant others;
- explore all alternative treatment options, with support from their clinician; inclusive of educating and involving family, whānau and significant others in treatment decisions;
- independent review, monitoring, and investigation – that tāngata whaiora have the right to a second opinion from an independent clinician, of their own choosing, and at no cost to the individual;

- have their requests for alternative treatment options monitored, independently reviewed, and with proactive intervention when the individual's rights and wellbeing are compromised; and,
- seek recourse from an independent body, such as a court, tribunal, or independent monitoring body.

Circumstances to override a person's treatment decision

The consultation process included a question about whether there are circumstances when a health practitioner should be able to override a person's decision about a particular treatment when they are under compulsory treatment.

Stakeholders emphasised the importance of advance directives. It was considered that the individual's wishes, as set out in an advance directive, need to be safeguarded. Some consultation hui stakeholders raised that there should be no situation where a sufficiently resourced and holistically-informed advance directive can be overridden by a clinician.

Of the small number of written submissions that responded to this question, it was commonly considered that supported decisions could be overridden if:

- tāngata whaiora had or seemed to have been compromised, such as where the decision seems at odds with the individual's known values, expectations and goals, it was not in their best interests, and/or where tāngata whaiora had been subject to manipulation or abuse by supporting parties.
- in specific risk or harm-related situations where there is strong evidence of imminent threat to life or significant harm.

An independent body to investigate complaints, monitor and review practice

Across stakeholders from consultation hui and written submissions, there was a high-level support for independent review of complaints and independent monitoring. There was no consensus over whether these two functions should reside in the same or separate independent bodies. There was a high degree of agreement, however, that independent body(s) should be framed around the human rights of tāngata whaiora.

Complaints and review

A need for independence was strongly suggested because experience has shown that internally reviewed complaints are not free from organisational or professional bias. We also heard of this need because existing mechanisms, such as district inspectors, can be "seen as an extension of the existing system rather than a truly independent voice". As such, the independence of those engaged in monitoring and review functions was considered of paramount importance, whether psychiatrists, legal experts, or peer support.

We heard mental health legislation needs to embed safeguards to ensure that family, whānau and significant others have a direct and immediate mechanism to raise concerns about their loved one's treatment and the failure of the mental health system to take their perspectives about the individual's care and treatment into account. Stakeholders outlined that the following matters should be considered to ensure a person-centred focus of any complaints process:

- clinician accountability;
- the timeliness with which complaints are addressed;
- the timeliness of reviews of restrictive practice and whether this has occurred "quickly"; and,
- the response timeframe should be monitored through an audit process.

Stakeholders considered that the creation of an independent review body would ease some of the responsibility and risk aversion carried by psychiatrists; with risk aversion seen as a key contributing factor for individuals being placed under the Act for extended periods of time.

We heard that reviewing the needs and wishes of tāngata whaiora should shift from a reliance on clinical expertise to include others who can provide a holistic understanding, beyond western medicine, and support the individual to communicate their experiences, needs and wishes. We heard that there is a need to make such processes culturally safe and to ensure a range of diverse perspectives are represented in the review. From those with lived experience we heard that the independent reviews should include clinicians, legal experts, mana whenua, family, whānau or significant others, lived experience peer advocates, and disability advocates.

There was also acknowledgement that tāngata whaiora need to determine who is present at any review, as it cannot be assumed that toxicity does not exist within the whānau. In this regard we heard from participants in the mental health sector that tāngata whaiora should determine who attends review meetings. We heard this aspect of tino rangatiratanga should be reflected in the legislation alongside the assurance that opportunities have been afforded for tāngata whaiora to define who they regard as their significant other(s) or have access to independent advocacy.

Monitoring

Stakeholders raised the need for an independent monitoring body to:

- ensure greater oversight over treatment decisions, processes, services (as experienced by tāngata whaiora) and the effectiveness of the individual's treatment;
- independently monitor the use of compulsory treatment and restrictive practices including psychological, cultural, lived experience and whānau perspectives; and,
- monitor treatment options are culturally appropriate, mana enhancing and include appropriate cultural involvement, including cultural advocates, kaumātua, has occurred in assessment and reviews.

We also heard the need for an independent body to monitor human rights associated with an individual's treatment. We heard there is a need to monitor specific aspects and indicators such as:

- use and length of time an individual is placed in seclusion;
- use and length of time an individual is mechanically or physically restrained;
- suicidality amongst those awaiting care and those receiving care;
- number of people waiting for an appointment with a mental health professional; and
- waiting lists for those attempting to access care.

Powers

We heard that such independent body(s) should have the following powers and responsibilities:

- constant and proactive monitoring and be empowered to make unannounced visits to mental health care facilities;
- inspect, investigate, reach findings;
- require substantive actions to address findings;
- review and overturn, discharge a compulsory order; and,
- hold clinicians and mental health treatment facilities to account by issuing penalties and sanctions.

Police

Arising from the consultation hui, those with lived experience raised caution about the role of police in responding to those in a mental health crisis. This was especially raised in relation to placing someone who is unwell in police custody. We heard that this is highly traumatic, and that legislation should explicitly state that this is not permitted.

From participants in the mental health sector we heard that the Mental Health Act can be misused and can unfairly remove an individual's rights. As such, these participants considered that the way police engage with the individual is essential, in particular all efforts need to be made to ensure the individual's mana is maintained and that practices avoid (re)traumatising the individual.

We heard that police are often the first responders when someone becomes acutely unwell. Some participants in the mental health sector described the way police respond to the individual can sometimes escalate an already delicate situation and "*they are pretty much bringing a person to hospital who was already very escalated, and it just gets worse*".

The small number of written submissions responding to the question of police involvement shared mixed opinions on the role of police ranging from no role, some role or maintenance of the status quo.

The main rationale for those who consider the police should have no role was due to the stigma, shame, agitation, and trauma arising from police involvement. The point was made that police are not health professionals, but rather their role is to police, and respond to offending and criminality. The involvement of police was not considered consistent with a recovery or human rights approach.

Those who supported the status quo suggested the role of the police is necessary to respond to situations of danger and harm, where they have specific powers to enter premises and detain. It was noted that no other professional body has similar powers. It was further suggested that the status quo should be maintained because police are frontline, trained, and available across the country.

Proponents of a limited role for police considered that their role should be focused on responding to situations of violence, criminal harm, imminent danger, and matters of safety.

We heard that there is an opportunity for police to adopt a different model of policing in response to mental health concerns. However, no consensus was reached surrounding what this new type of policing might entail. Rather, some from the mental health sector discussed the need for the police to adopt a more “humanistic role”. Others discussed the need for specialist police trained in mental health responsiveness while others suggested police should respond to mental health crises in collaboration with Māori wardens or other non-police roles.

Some of the written submissions emphasised the need for police to be educated on the legislation and mental health as well as having appropriate skills to effectively respond to and engage with tāngata whaiora and their whānau. We heard of the importance that communication is respectful, compassionate, and trauma-informed.

It was suggested that humanistic policing could include dedicated uniforms to distinguish officers specialising in mental health from general policing. We heard that this, coupled with appropriate training, would minimise the risk of escalation. Feedback also identified the opportunity to respond to mental health crises in tandem with health professionals, inclusive of peer advocates and specialist nurses. We heard that a more holistic crisis response needs to be explored in-depth and that the identification of a best practice model should be embedded in legislation. An example was offered of the Wellington Mental Health Co-Response Team pilot, which is a joint initiative between Police, Wellington Free Ambulance and Capital and Coast DHB. There could also be a special multidisciplinary team located within police that responds to mental health events.

Also submitted was the idea of a dedicated ambulance, paramedic first response service which would enable a healthcare professional unit to respond to calls, not police. This is a model used in New South Wales, Australia.

Many of the written submissions emphasised the inappropriateness of tāngata whaiora being held at police stations and in police cells pending assessment, and that police stations and cells should have no place. Rather, there should be appropriate spaces available in hospitals and facilities.

District Inspectors

Some Duly Authorised Officers and some members of the wider mental health sector emphasised that district inspectors play a key role in maintaining individual’s rights and they suggested the district inspector role:

- should be maintained;
- should be expanded;
- could be improved by involving district inspectors earlier in the process;
- should include working in collaboration with cultural stakeholders, although the explicit role of cultural stakeholders was not articulated;
- should be extended to support tāngata whaiora understand their legal rights.

Duly Authorised Officers suggested that provision for advocates should be made during court hearings under the Mental Health Act. Such advocates could be whānau, other support people, lawyers, independent peer advocates, cultural advisors and kaiawhina.

Special and restricted patients

The Criminal Procedure (Mentally Impaired Persons) Act 2003 allows Courts to find people being charged with a crime either not guilty by reason of insanity or unfit to stand trial. In either of these instances, the people then become ‘special patients’ and receive mental health treatment in a secure environment. It is important that the special and restricted patients are included in discussions around the Mental Health Act and any future changes.

We heard from consultation hui participants that this is a challenging area. Forensic services and prison representatives reported increases in tāngata whaiora receiving a custodial sentence, where it is common for these tāngata whaiora not to receive treatment or support. There was a sense that special patients have the same rights to person-centred health care as all tāngata whaiora. Additionally, participants considered that these tāngata whaiora are entitled to better planning, holistic service provision and transparent reviews. Within this context we heard there is an urgent need to ensure the rights of special and restricted patients are being protected.

A small number of submissions responded to the question regarding how legislation should treat a person with decision-making capacity in the justice system who does not want to receive mental health treatment. Submissions fell into three main views:

- compulsory treatment should be required – there is particular concern about the individual being a danger to others now or in the future if not treated;
- legislation should recognise choice and the right not to receive treatment and this should be respected. According to one stakeholder, options should be offered and

facilitated alongside acute inpatient admission and with an assessment to determine what is needed to ensure safety; and,
- the individual should be treated no differently than a person not in the justice system.

From a victim of crime perspective, one submitter considered that victims should have a right to request a non-association/ no contact order on submission to the Mental Health Review Tribunal, when the Tribunal considers an individual coming off the Act. Further, and as in Queensland and New South Wales, the legislation should provide for Victim Impact Statements to be submitted to the Mental Health Review Tribunal.

Submitters were also asked how compulsory mental health treatment should apply for a person found not guilty by reason of insanity. Of the few responses received on this issue, two positions were identified:

- there should be compulsory treatment with the focus being on treating the illness and not the offending. Treatment should be regularly reviewed and provided for the minimum amount of time required; or,
- compulsory treatment should only be used if criteria for compulsion is met (not based on special status alone).

Finally, submitters were also asked how legislative requirements relating to people in the justice system would affect particular population groups. Few responses were received on this issue and there was no consensus. Different views included that:

- people with mental health issues and disabilities should be in hospital not prison;
- it is important that everyone is represented and heard;
- there is a need for extra family, whānau, other support for disabled people;
- victims must be told where an individual is being held and when they are released;
- community treatment orders should remain in place if needed when the status of an individual changes from being on remand to becoming a sentenced prisoner; and,
- there needs to be alignment to human rights law and international conventions.

Appendices

Appendix 1: Lived Experience

Appendix 2: Family, whānau and significant others

Appendix 3: Māori mental health sector

Appendix 4: General mental health sector

Appendix 5: Organisations who provided a written submission

APPENDIX 1: LIVED EXPERIENCE

CONTEXT

We heard from those with lived experience that mental health legislation needs to be made more relevant and empowering, providing the individual with protections under a human rights framework.

Multiple accounts were provided whereby those with lived experience were traumatised under the Act. Descriptions such as torture as well as hostile and culturally unsafe or unresponsive treatment were common.

> *The key is it's not it's not care. It's hostile. (Lived experience, disabled person)*
>
> *Those with lived experience outlined that acute mental health settings often feel so unsafe that tāngata whaiora ask to be placed in seclusion, despite seclusion being an agonising experience for them. We heard that there is a need to change clinical culture and environments to ensure that people feel safe.*
>
> *So some people have spoken about, around how sometimes people with lived experience will find themselves on wards asking for seclusion. When it isn't seclusion, that the wanting is actually a quiet place where they can feel settled ... particularly for people with sensory processing or who are autistic. Additionally, I've spoken with woman who have said that when they felt unsafe on the ward, they often seclusion this felt like a more viable option for them as a consequence of the trauma. (Lived experience, disabled person)*

While traumatic experiences were common, we also heard about traumatic experiences specific to those living with a disability. We heard of disabled people’s means of communication and mobility having been removed. We also heard of no accommodation being made for those living with neurodiversity.

> *A lot of the notes and stuff that I've written is around that, because I just believe we don't have any [accommodations made]…, as an autistic person with mental health issues… the inpatient services are not suitable for me in multiple ways. And yet, there's no services available when I'm in crisis. And I actually needed to be in hospital. But there's no place that it's appropriate standard of care for me. And it was very complex. And it was my family and my, my whānau and they actually felt that I needed to sit there and let them sort it out. And so I went, as I consented to be under the Act, in agreement with my family, my lawyers to try and give them time to figure out how they could actually provide services that aren't there. And it's been an absolute disaster. And as soon as they realized what we were actually doing, by me consenting to the act, they just power played because I had no control over staying on the Act, once the clinicians decided shit, they're actually being put in a position to take responsibility for providing support and help. And so as soon as they realize that they*

> *withdrew the Mental Health Act, and I felt unprotected and unsafe. (Lived experience, disabled person)*

> *The wards are actually terrible for an autistic person. The wards, the sensory design, the environments badly designed, there's washing machines in the middle of the main areas, when they're having meetings, the noise, the acoustics, the in terms of sensory stuff, it is diabolical, than in terms of people that have dietary needs. The dietary like, especially things like coeliacs and any kind of dietary needs are poorly in fact that I just it was a struggle in the whole four months I was there to get food that I could eat. (Lived experience, disabled person)*

We heard that the Mental Health Act has been used coercively to force individuals to receive treatment. We heard that tāngata whaiora often do not understand the Act or the criteria that sits within the Act. This lack of understanding makes it easier for tāngata to be coerced.

> *I feel like it's all comes down to how you interpret the legislation or anything. You know, it's all very well to put something down on paper, but that that can be used coercively, or it can be used to support the individual. You want to have legislation that's enabling and supportive and not damaging. (Lived experience)*

> *I think it gets misused a lot at the moment. … a very common experiences, people get admitted voluntarily and then as soon as they say I want to leave the ward, the Act has kind of held over them. If you leave, we will now invoke the Act. So they kind of stay off the Act, but it's used as a threat of behavior again, yeah. And people [have]none of the protections of the Act but all the compulsion of it really, effectively. It's coercive by stealth. (Lived experience)*

> *I think that going in as a voluntary patient, actually as it is currently has some real risks. And one of the reasons I consented to being on the Act in the last year, in the last four months or so, , because my experience of being a volunteer was extremely coercive. That basically, every time I didn't do what people wanted me to do it was like, "Well, you don't have you don't have to be here so go". So I found actually being a volunteer harder. And I had I felt protected under the Mental Health Act, this time, to a degree and I had a lot of a lot of the things the judge said in the process of going under the Act was helpful and recorded. But then, once mental health realize that actually the Act was protecting me, they, the clinicians just took it out off. So once the Act actually came off, I didn't feel safe or protected. And there was no obligation on their part actually have any responsibility for the process, and provide support and it actually became very unsafe and more harmful. And I ended up leaving, once the Act was removed. And to me it was a real power play. (Lived experience, disabled)*

> *so I was in a tough situation where long time the psychiatrist was saying, because I was so suicidal, that if you don't become a volunteer, we'll put you under the Act and sort of say, well, you know, so there's a lot of it's better to be a volunteer, and you've got more choice and more say and everything, but I didn't actually experience it that*

> *way. Because being a volunteer, I wanted to comply, and I wanted to work with people and stuff like that. But I was actually being told by the psychiatrist, if I'm not a volunteer, they will commit me. And then I had the nursing staff saying you do what you're told or otherwise you leave, go, just go. And it was very, mind fucking. (Lived experience, disabled person)*

We heard that there is a need for a paradigm shift – the current approach to acute mental health is risk aversion and such clinical attitudes act as a barrier to the mental health workforce listening to the needs and wishes of tāngata whaiora.

> *I'll step back and I mean, I do have a lot of psychiatrist friends and I think they are also being put in a hard position because they're required, you know, they could be in trouble if someone … says they want to leave, they let them leave, and then they go commit suicide or have, you know, a criminal act. As part of this, the, you know, making people responsible for their own decisions, they shouldn't be responsible for a patient that does do something off because that's, that's what makes them want to, you know, they're trying to protect themselves. (Lived experience)*

SYSTEM AND SERVICE FRAMEWORK

From those with lived experience, a number of recommendations were made around changes to the mental health system that would significantly reduce rates of compulsion.

- Sufficient resourcing and coordination to enable tāngata whaiora to receive comprehensive services. The provision of early engagement with comprehensive services would reduce the risk of escalating mental distress that might result in the individual coming under the Act.
- Assessment and service provision needs to view tāngata whaiora holistically and thereby remove classifications that result in siloed and disparate service delivery (for example the individual having to access different service providers for diabetes and mental health). We heard that removal of artificial classifications would significantly contribute to the delivery of seamless care and wrap-around support across services, systems, and the sector in general.

> *Most of the problems I've had in the last few years is because people are saying that like trying to get the collaboration with the services between all the different parts. I've got so many people go to ACC, disability, mental health, you know, just everybody from all these different aspects and none of them can work together. It's been so freakin' complicated. At the end of the day, I'm sitting out here with none of my needs met, it's pumping hundreds of 1000s of dollars into people trying to collaborate. (Lived experience, disabled person)*

> *Now, I think they need to stop labeling with diagnoses as well. And start looking at people holistically and just assume that everybody's got a whole lot of different things and start focusing in on the individual, regardless of all those different aspects of them*

> *and treating people holistically and that has to be put into the legislation. (Lived experience, disabled person)*
>
> *My sister gave me this lovely analogy and I think it's brilliant and it works really well with the disability stuff in the things. She said, the support needs that you need. You need an apple and you've been asking for an apple and you've been really clear that it's an apple that you need and they're saying Here, we've got these oranges. And we've got these pears, we've got the bananas, we've got these grapes and go, you're ungrateful because we're just giving you all of this fruit all over the place. We've got this massive big fruit basket. But there's no apples in there. (Lived experience, disabled person)*
>
> *I'm on this bloody fruit basket with all these exotic fruits and everything and so much of it. But at the end of the day, I still don't have my apples. Not only have they given you a fruit basket, but they've, they've put it on a really high shelf, and you don't hear the letter. So you're not quite sure how to get up, get up, get up to this beautiful, I don't even I don't even need any of these fruits. They have no relevance to me. And then you might be allergic to them. Yeah.. I just need a frickin' apple. (Lived experience, disabled person)*
>
> *I think, I think one of the problems with looking at the mental health that because we've got such a diversity of presenting symptoms, or presenting types of people, and you're trying to deal with them all through one type of care and like, in a way that really is destined to fail, you know,. You wouldn't do that with any physical health problems. I mean, you know, we try and you try and lump all cancers together, you even try and lump all leukemias together. All leukemias are so different, you know, and yet here we are treating anorexia, which is in psychotic behaviors and meth addiction with the same treatment mechanisms. It's like, that's not gonna work. (Lived experience)*

Appropriately designed inpatient environments – low sensory environments, provision for wheelchair accessibility, and accommodation for those with a physical disability.

> *Accessible. (Lived experience, disabled person)*
>
> *Accessibility, it's absolutely the biggest thing. If you can't get into the services, or you can't get treatment, or you can't get out of your house, because of disability, then you're kind of stuck. That's the end of that. (Lived experience, disabled person)*
>
> *There needs to be of an appropriate standard. (Lived experience, disabled person)*
>
> *The inpatient treatment is not of an appropriate standard. The environments not appropriate standard. The training of staff is not an appropriate standard. The there's multiple issues. (Lived experience, disabled person)*
>
> *I've thought regarding accommodations necessary for the care and wellbeing of the individual, whether there is the including mobility devices, communication, travel, personal care, if they have support people that have come into the home to help them*

> *with bathing, and things like that, that has to keep continuing in an inpatient setting. (Lived experience, disabled person)*

Staff trained in how to provide care to those living with a disability, inclusive of neurodiversity.

> *And I think also an understanding that disability is not a lack of competency or being able to make decisions, and it's also not necessarily the cause of mental trauma or stress. Yeah. That's something I've come up against quite a lot is … the assumption that everything that's going on, that's leading me to needing services or needing help has been based on the disability I'm experiencing, and I've had to say no, and try and prove to get the right accommodation or care that No, I'm not experiencing depression because I'm blind. These other things that have happened, you know, and try and get appropriate care around that. And that's been an ongoing issue that I found with a lot of our youth service staff and care providers. (Lived experience, disabled person)*

> *Staff need to know about disability. So there's some education stuff that needs to be an appropriate standard. (Lived experience, disabled person)*

> *And my experience is that I've had my cane, I'm blind, I use a cane to get around. I've had my cane and my glasses taken away within mental health settings. And I've only been given them back. Once I've kicked up a fuss and been like, Hey, I actually need these things and had other staff get involved. So it's a it's a staffing level, that. Inconsistency and whether these are necessary, or if the too risky. Which leaves me in a, you know, being without my cane in a place where I don't know my way around, don't have trust in the staff's abilities to guide things like that. It's a big, big stress for me. (Lived experience, disabled person)*

> *That it's a it's say, ableism. And the lack of value that some people hold for people with disabilities that disabled person's life is less or, of course, they're not happy. They have a disability, you know, like, yeah, it's that that ableism stuff will come in. And, that's also why I believe that there needs to be specialist training around this and absolute around providing this sort of care for people with disabilities. (Lived experience, disabled person)*

> *My mental health needs, nothing therapeutic happened, in my whole time, was been battling the accessibility issues.. (Lived experience, disabled person)*

All clinical staff need to be trained to provide care to tāngata whaiora Māori that is culturally safe and competent.

Tāngata whaiora, and especially Māori, need te ao Māori to be embedded in all mental health environments, especially acute care units.

From those with lived experience we heard support for smaller acute mental health care settings and the provision for peer acute alternatives. Such settings were furthered as reducing stress and therefore reducing the potential for the need for restrictive practices.

There was a respite service here in question in Canterbury for a while, what I always thought if I had to go somewhere, that's where I want to go. And it was four bedrooms. It was like a luxury retreat, in the country, you know, another one, you made a lot of Lord of the Rings, I think it was Rivendale, something like that. I'm not sure if they're operating as a respite anymore. But yeah, out in the country. So it fitted they were out in nature and the environment, people were treated with a lot of dignity and mana, because it was a beautiful environment, even the rooms were really well appointed. (Lived experience)

There's a little bit, you know, pathways run a couple of peer run acute alternatives. Again, I think they're probably a little bit vague. And that's, that's getting down to resourcing, you know, who was involved in the one here in Christchurch getting set up. And the very initial conversations and a lot of it was about, in order for it to be economic, it needs to be at least 10 beds or at least 12 beds or whatever, you know, we're so I think we've just we've got to resource this completely differently. And know that if we put that money in upfront, it's going to save us so much money in so many, you know, the productivity for people, I just don't think we cost the stuff accurately either. We're not putting in all the costs of lost productivity for lost social inclusion. lost potential from people. When our system does fail them. But yeah, so yeah, smaller, you're making some inroads with like smaller units, mental health system, that prioritizes connection in relational understanding, that's going to mean better resourced system, much differently trained staff. And I think the open dialog approach is a lot to recommend. (Lived experience)

So we've got to, I mean, what it comes back to me is a paradigm shift again, around relational practice, at all levels across community and specialists, you know, secondary and tertiary services, I think we've got to get into more like, much, much smaller homey kind of units get away from the hospital. One of my theories about hospital treatment, which our whole health system was built on is it's a military model, which is fantastic for delivering scarce resources efficiently. You know, just apportioning your limited resources and the most triaged effective way. But it means we have this hierarchy of responsibility. Where in mental health the psychiatrist, consultant psychiatrist is like God. So it's that kind of paradigm, it doesn't fit, it doesn't fit anything we know about what is helpful for managing mental distress. So we've got to break that system, we've got to do something completely different. (Lived experience)

There's all that talk of how do we have more beds and inpatient units? Can we get paid somewhere else place? Because those are the spaces that won't have restrictive practice. And if you have more space in your units, then you have a better environment to have less restrictive practice occurring anyway. (Lived experience, Māori)

There is a need for post-compulsory treatment support to assist individuals to heal from the trauma associated with their compulsory treatment whilst ensuring treatment-based trauma is monitored and stopped, going forward.

> *I think that appropriate trauma support should be offered afterwards. I know that too many people that are in therapy now because of the traumatic experiences that they went through, in the health in the healthcare system, you know, and, I mean, I'm one of those people, I've spent now $1000s of dollars on treatment, to overcome the horrible experiences that I had. And it's just like that, that to me should be an ACC claim that was completely induced by my experiences of the system. So and there's no recognition or acknowledgement, really, that that what we experience. (Lived experience)*

SHOULD THERE BE COMPULSION?

Lived experience participants offered a high degree of support for the removal of compulsion from mental health legislation. We heard that compulsion is counter to human rights, retraumatises people who are already in distress and does not address the trauma underpinning most mental distress.

> *It's compulsory, it's not very comforting and it doesn't promote tino rangatiratanga… just having that empowerment, this is taken away from you. So and that's really tough, you know, and … on top of everything that's going for the person now, and that the stress in having that compulsory thing on top of there, you know, makes the burden a lot more so that'll add extra stress. And so I can imagine that, you know, yeah, things just become bigger then. I believe that, though it should not become compulsory. (Lived experience, Pasifika)*

> *I don't know of anybody that's had a good experience coming out of it. And even just, I would say, the second hand trauma of seeing other people being put under the Act, and the powerlessness that people have, and especially when they're in such a vulnerable state, I think we can do much better. You know, we should be there to help and support people and not contribute to their suffering. (Lived experience)*

> *Should it be compulsory to put somebody on treatment? So my answer to that question in a nutshell is no. I don't think that. Do you think the law should ever make people have compulsory treatment? My answer is no, I don't think the law should do. (Lived experience, Pasifika)*

> *But when they walk into that situation, totally, like, what [name removed] said, is a little bit cold or mixed up with other people stuck in the same situation. Everybody, they scream from the inside, from their head or whatever. They want something safe. But I suppose both the people who want to support and help, they got the fear. And these people they need to help, pick up the fear. That's what's happening right now (Lived experience, Asian)*

Those in favour of significant reductions or total removal of compulsion

Those who supported the removal of compulsion from statute referenced the incompatibility of a human rights framework and compulsion.

> *I'm thinking if we want to take a human rights approach, then we've got to absolutely minimize the amount of compulsions, that's got to go much further down the other end of the scale. And again, thinking off the top of my head, we have coercion and compulsion around breaking the law like we have the police, and if people do something that's outside of those social norms that have been mandated in that way, that process already there, so what do we need on top of it? Especially, when we know the impact and relationship and the additional distress that can cause with compulsory treatment is put in place? (Lived experience)*

We also heard that no compulsion requires a shift in the way we view mental distress, which can lead to misdiagnosis and misuse of the Act. This was especially noted for Māori. We heard that a reliance on dominant western biomedical psychiatric models has resulted in a singular privileging of psychiatry. Rather, participants strongly suggested there is a need to focus on models of early intervention and holistic support. This would require "providing comprehensive support and services earlier on in a person's journey". We heard that support should include the appropriate implementation and widespread use of advance directives and adequate resourcing for mental health support, particularly peer and cultural support. We heard there is a need to shift mental health legislation from a singular crisis intervention focus to prevention and early intervention. We also heard that this would require a financial commitment from the government and that new legislation should provide this direction.

> *What I would like to see is a different approach to how we regard mental distress. We know there's kind of like a big gap between what people access at home and in their community and then into specialist services. So, if there was no compulsory treatment, I'd love to see a more comprehensive sense of coverage across all the range of experiences that people have. So it wasn't just kind of, okay, we are here, step through GP brief intervention, …and this big, big, big gap before you can get into anything through crisis. That would mean a different perspective around mental distress and how it is "managed" or dealt with. (Lived experience, Peer advocate)*
>
> *For a lot of Asians who experience mental health distress were due to migrations, settlement issues, communication, intergeneration issues. So all that can be addressed. And don't have to wait until things were, you know, like, breaking into pieces. (Lived experience, Asian)*
>
> *One thing that I've found, it's very ironic now is that there's this compulsion for some people, but then other people can't get help when they want it. There's a long waiting list. …And so I think that, actually, I think the Act ought to require the government to put in more resources. I think what the Act ought to do, is there should be more resources available for people who want need help. (Lived experience)*

From those with lived experience we heard that the provision of comprehensive mental health care, adequate resourcing and holistic support would mean compulsion would become a rarely required alternative.

> *One is financial and two is resources. I mean, my understanding is we have a massive shortage of psychologists and psychiatrists, right. And I'm going to assume that extends to other areas of mental health services in terms of peer support workers, counsellors, addiction specialists, whatever. So sometimes, even if you pump the money in if you don't have skilled professionals available, you know, you still can't provide that service. So yeah, I guess, if you got really serious about offering pay increases, you'd end up with enough people working in that area. Yeah. (Lived experience)*
>
> *So yeah, I mean, I think if you were to truly focus on a no compulsion objective, you would need a lot of de-escalation very early on in the person's journey. And I don't see New Zealand having that level of commitment to providing those services. So yeah, you know, we would have a lot of community based support, you would have endless access to mental health services, and peer support, you know, you would get to choose 100% of your treatment plan, and you would know all your options straight up, you know, so that when you were in the right frame of mind, you could you could make your decisions early on, you know. (Lived experience)*

We heard from tāngata whaiora Māori that compulsion does not align with a te ao Māori worldview. We heard that whānau Māori want access to kaupapa Māori services and supports that will enable them to get the right care, at the right time, for their tāngata whaiora whānau members.

We also heard from Pacific people of lived experience that compulsion is counter to Pacific worldviews and practice that rests on the influence of family to encourage and support the individual to access care. There was a belief that this means family should be provided greater supports to be able to support their tāngata ola.

> *I just want to just, something's just come up. I'm coming from a whānau perspective. Supporting somebody with the experience can be looked at differently, because it can safeguard, got a lot of pressure on the family. So you know, having them maybe under a certain, I don't know, like a, like a kind of a protection blanket, you know, like their whānau become safe. (Lived experience, Pasifika)*

Those who are cautious about a complete removal of compulsion

We heard that many people want there to be no compulsion but do not believe this is currently possible without a significant shift in the way services and systems operate.

From some with lived experience there was concern that removal of all compulsion may leave some people vulnerable.

> *I have some mixed thoughts about that, I suppose. In a way it's ideal. But I think that actually having no compulsory treatment leaves people vulnerable when people are actually needing protection, and there are concerns. (Lived experience, disabled)*

> *I think it would be, you know, a perfect world scenario if there was no compulsion. I struggled to envisage a way in which you could have no compulsion, because although I think a lot of people have had really terrible experiences. I also know of scenarios where people were not able to make decisions for themselves. And you could potentially leave people in further unsafe scenarios, by not having a responsible person looking after their care. (Lived experience)*

Some participants described situations when some degree of compulsion might be required, namely when someone has no previous mental health diagnosis and suddenly experiences an acute mental health crisis. We heard that this was a concern when no advance directive is in place.

> *Yeah, yeah. And saying that I'm not sure what [name removed] experiences with the psychotic breaks scenario, like say my friend's mom, she unexpectedly had a psychotic break and ended up hospitalized. And yeah, I mean, it happened so rapidly, she really couldn't make decisions for her own care. And I still looking at that scenario don't know how that could have been avoided. And, you know, I think in that situation, it was important that there was another avenue. (Lived experience)*

> *I think that treatment should be a choice. What kind of treatment they after? It's a bit tricky if it's a person's first time entering the system. (Lived experience, Pasifika)*

We also heard concern that those who are unwell, without appropriate mental health legislation risk entering the criminal justice system, as opposed to being assisted by the health system.

> *If there was no compulsion would those people at that extreme end of risk just end up in the justice kind of side of legislation, which would be a travesty. (Lived experience, Māori)*

> *I also feel like people in prisons need to have, if people do I mean, I know, it's rare that people actually commit crimes, while they're mentally ill, but sometimes it does happen. And I think there needs to be something so they don't just get thrown in jail, just because they were not able to think clearly at a time. So I feel there needs to be something for that case. (Lived experience)*

> *Well, actually, I agree with [name removed], I think there needs to be something about it for criminal things. (Lived experience)*

IF THERE IS SOME COMPULSION WHAT WOULD IT LOOK LIKE?

Those with lived experience strongly suggested that mental health legislation needs to adhere to a human rights framework and international conventions, such as the Convention on the Rights of Persons with a Disability and the UN Declaration on the Rights of Indigenous Peoples. Within this context, we heard that new mental health legislation should position the individual's rights to decision-making within a context of their wider social support structure, albeit whakapapa or friendship networks.

We heard that assessment and service provision needs to view tāngata whaiora holistically and thereby remove classifications that result in siloed and disparate service delivery (for example the individual having to access different service providers for diabetes and mental health). We heard that removal of such artificial classifications would significantly contribute to the delivery of seamless care and wrap-around support across services, systems, and the sector in general.

> *And they try to categorize everybody and because most people are a whole mixture of things, what it's doing is it's actually stopping people being treated holistically. And a lot of the wonderful things like Te Whare Tapu Wha and that is not able to be looked at under mental health because they're trying to put everybody in these boxes. And in a lot of the reason, like I've struggled in the last period of time, because of now that I have this autistic diagnosis, mental health are saying, well, you're not our problem, you actually come under disability. And, you know, I'm also gay and you know, there's, there's, there's a whole lot of mixture of things, because I've got mental health issues. (Lived experience, disabled person)*

We heard that compulsion is a complex issue but that decisions surrounding intervention should align with an individual's wishes, whether the individual dictates that compulsion is appropriate in the event they experience acute mental distress. In this regard, advance directives were described as essential and that they should be appropriately implemented and monitored. We also heard that mental health legislation should prevent clinicians from overriding advance directives.

> *Thinking that something like more represented in, in someone's care when they're doing well to be able to write a crisis plan and so that can be more of a living document. Yeah. (Lived experience, Pasifika)*
>
> *Just one I want to ask .. if compulsory treatment is not abolished then I would like to see advance directives because, at the moment, they can be overridden which increases the sense of powerlessness. And so people are feeling like we haven't got anything hopeful or to lock into around. Yeah. And I've heard many stories of that, you know, and they're like, to me, what's the point Matua? You know, you don't dam! That's what I want to see if better .. if we cant abolish compulsory treatment. (Lived experience, Pasifika)*

TE TIRITI O WAITANGI

From those with lived experience we heard of the importance of embedding Te Tiriti (te reo Māori version) rather than the Treaty of Waitangi (English version) in new mental health legislation.

> *I think one other point and [name removed] did kind of touch on it when he was talking about kind of the difference between understandings of, you know, principles versus articles. And it's come up a lot in terms of also, which version of the Treaty are we talking about? And being really clear, and from a te ao Māori point of view, that if you're talking about Te Tiriti that it has some different connotations to us traditionally talked about the Treaty. And that has significant implications when you're talking about legislation in terms of people's rights. (Lived experience, Māori)*
>
> *I think I mean, we have to face that the version that was written in te reo Māori surely for all of these things. It's that's the international law as much. Yeah, so what this suggests to me is that it really bears repeating - isn't regarded as obvious - is to be explicitly reminded. (Lived experience)*

We heard acknowledgement of the inequitable experiences of tāngata whaiora Māori and the even greater vulnerabilities of tāngata whaiora Māori living with a disability(s). Within the context of Te Tiriti we heard that new mental health legislation provides an essential opportunity for tāngata whaiora Māori to actively participate in the ongoing development of mental health responsiveness. In this sense, tāngata whaiora Māori were positioned as an essential participatory voice in the design, implementation, and process-related reviews.

> *The data shows that people, Māori adults, are less likely to have their needs met, are less likely to consult with health professionals. And that does include mental health. Because, you know, there's a distrust, there's a, you know, non-connection. So it is really important that people respect and it's basically honouring the Treaty and the participation, but allowing people to have their voice and have their say, in being part of this sort of conversation. So there is a huge amount of work that can be done and generally those at the top, we need to have Māori disabled in there to share the experiences and to be the leads because it's all very well for a Pākehā disabled person to be up there, or as [name removed] was saying a non-disabled person running the show with this new Commission. It's like, well, actually, you're missing the boat guys. This is our opportunity and, you know, you've got to start out the way we need to carry it on. And we do need Māori and Pasifika, and everybody, Rainbow community, because there's a lot of Rainbow disability, it's not just the equity lens is everybody that's marginalized, the homeless, the aged living in isolation at home, would they be a part of that? As well as mental health of course. So, yeah, anyway, that's my rant for the day. (Lived experience, Māori disabled person)*

We also heard that Te Tiriti should be reflected in the development of Māori-centred legislation, with the understanding that the principles embedded within the legislation would simultaneously benefit tauiwi. There was support for this approach on the basis that Māori will continue to experience inequities if legislation adopts a simplistic approach of attempting "to put a Māori lens across" legislation.

> *There is so much equity that manifests through the Act, and some of it inequity is the way the Act is designed. But, you know, there's also a lot of inequity that comes into the Act. Like that there's, you know, just with the systemic racism, with colonisation, like there is always going to be that inequity coming into the Act, so whatever happens more Māori are going to experience it as things currently stand. So rather than looking at what you do can do to make sure Māori worldview and Māori are accommodated and all that kind of stuff like. How would you actually just design a Māori Act that then was for everyone, or that those principles flow through and that they would actually work better for everyone that actually a te ao Māori view is around holistic wellbeing, is around rangatiratanga, but also that manaakitanga of care and caring for people and actually how we actually stop thinking about how we try to put a Māori lens across this and actually start thinking about designing something that is just from your point of view. (Lived experience, Māori)*

> *Let's approach it from a te ao Māori lens right from the beginning because I think when you get the stuff right from the start, you get it right for everybody. Again, coming from the peer support angle, the te ao Māori lens is much more about relationship and whole in meaning on the sort of holistic, meaning, you know, including wider, which is so lacking for somebody Pākehā. I think that's part of our kind of disposition around this stuff. So yeah, I think getting it right from a Māori lens right from the beginning would be the best angle. And for Māori, that might mean having some of the process does take place on my learning from existing systems that we've got in place or structures that we put in place. I'm looking at my other screen, it's got the thought starter document as well. And so some of what [name removed] said really resonated for me as well in terms of some of the principles that we've got to there's a lot of talk and health about mana enhancing practice. But this whatever we come up with, absolutely has to have that at its heart. And again, I think if we get that, right, it's right for everybody, including everybody. (Lived experience, Māori)*

We heard that the mental health workforce's engagement with tāngata whaiora, and their whānau, should be centred on mana enhancing practice, manaakitanga, whanaungatanga and kotahitanga.

Many with lived experience expressed a lack of confidence surrounding Te Tiriti and its application to mental health legislation. Rather than referring to Te Tiriti principles or articles, this cohort referred to the importance of key aspects of te ao Māori being reflected in mental health legislation.

Te Ao Māori Tenet	Description	Quote
Tino rangatiratanga	Devolve mental health service provision to Māori	*The best thing is for decisions that the Act would have normally made, and the powers that are given in the Act to all of the mental health professionals for that power and those decisions to actually be given to Iwi. (Lived experience, Māori)*
Rangatiratanga of tāngata whaiora[3]	We heard tino rangatiratanga means that tāngata whaiora have the right to make their own decisions.	*Everyone would benefit from having some of the Māori cultural aspects introduced into mental health care. You know, like tino rangatiratanga. I think every patient should be able to have that by right. (Lived experience, Māori)*
Whānau	Te ao Māori whānau-centric view was stressed as vital. On one significant level this was deemed as a central tenet of te ao Māori. However, for non-Māori family was equally regarded as essential. Those with lived experience stressed one of the important	*Yeah, and whānau is really important as well. That's, yeah, years of consistent advocacy has showed me that family often have, I mean, family and service users will people in the streets often have a lot of stuff in common about what they want to see happen. But where they differ, the differences can be significant. So taking a whānau perspective, right from the beginning, I think, will help that as well, just reminding all of us that we exist within groups, not always blood ties, but you know, humans are social animals in taking the group collective whānau angle work from the beginning would be helpful. (Lived experience)*

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[3] Participants about rangatiratanga in relation to individuals. It is acknowledged that rangatiratanga is typically understood to be about collective rights (for example, tāngata whaiora in the context of their whānau, hapū and Iwi) and not in relation to an individuals rights.

	aspects of whānau rests in the strength of collective decision-making.	*And I thought that whole collective group whānau approach also links into some of my thoughts around that whole, you know, how people are assessed and how capacity is assessed and how individualistic nature isn't, and culturally appropriate in so many ways, but also is quite culturally appropriate from like a human culture. (Lived experience, Māori)*
Mātauranga Māori	Provision for the treatment of tāngata whaiora should include the possibility of engaging in te ao Māori practices. Such provisions include: ▪ te ao Māori healing practices (that may occur outside of a western clinical setting) ▪ ensuring clinical environments include provision for kaumātua and tohunga.	*Also about place, I am thinking about how some of the processes have been taken back to the marae. (Lived experience)* *I'll link it back with what I said before around, you know, if we're speaking about some more specifics in this space around that recognition of tohunga. And, you know, so many other people are kind of named and specified. You know, in the Act as it currently stands, and actually, consultation isn't enough decision-making power needs to be allocated. (Lived experience)*

CAPACITY AND DECISION-MAKING

Introduction of a test of capacity

We heard from those with lived experience that capacity needs to be appreciated within a mental health system that has often not provided the individual with the early intervention and support; despite the individual's repeated efforts to access such support. As a consequence, mental distress has commonly escalated and resulted in the individual being placed under the Mental Health Act. Within this context, early intervention and support would have greatly reduce questions of capacity in times of crisis.

> *Yeah, and again, I would go back to the whole, try other de-escalation techniques, I certainly know of situations where I've had friends who have asked for help and asked for help and not been able to access it or receive it. And it's escalated to the point where they're put under the Mental Health Act, and treatments that have been used on them against their wishes, when they'd been asking originally for something else, which they hadn't been able to access, you know, and it's like, this is just ridiculous. We've been trying for months to get this person to have some kind of care or support. And we were told there's like no beds available for them, or like no psychiatrist, they can see, you know, and yeah, they've ended up under the Mental Health Act, it's completely inappropriate use of the Act. So can we make sure that they're given the ability to make decisions when they do have capacity, you know, again, Advance directives thing. (Lived experience)*

We also heard that the western bio-medical model commonly negates the negatively "labelled" individual's ability to make their own decisions and disempowerment begins at the point of assessment. It negatively impacts how mental health clinicians understand a person's insights and is then used as justification for questioning a person's perspectives, including their decisions. It also negatively impacts how a person's complaint is listened to, or whether any accommodations are made in regard to self-defined needs. Further, poor practice, including racism and cultural incompetence, often results in hastily derived diagnoses and treatment plans. This practice is in contrast to the wishes of those with lived experience who advocated for a change in the way clinicians engage with those experiencing distress or mental unwellness which currently results in the individual's wishes being overridden. Those with lived experience said that this shift requires clinical staff spending longer periods of time spent with the individual and a commitment to understanding the individual's experiences, needs and wishes; not limited to the individual's diagnosis.

> *My overall thoughts are as well though, that I think more people that are experiencing mental distress are able to make decisions for themselves, than healthcare practitioners give them credit for, I think, a lot of the time, their ideas might come out as confused, or they might have what we deem irrational behaviour. But it doesn't mean that they are not able to make decisions for themselves, you just really have to*

> *be listening. And I think it's easier sometimes for people to just be like that person's irrational, let's just make a decision for them. But actually, if you took the time to, like, get to understand how that person is trying to communicate, you will learn that they know what they want and need. (Lived experience)*
>
> *Overarching, I got treated like I was completely stupid the whole way through the system, you know, which is not true. I actually am really highly qualified. But you know, when you're in a certain state of mental distress, I know people conflate that with stupidity. And it's not the same thing. (Lived experience)*

From those with lived experience we heard support for the inclusion of capacity in new mental health legislation.

> *But I did really like the concept of creating something that was consistent with the way that decision-making capacity is tested in other parts of health. So I think we need to be looking for something that's consistent across health, not just a sort of mental health specific thing. It should be something that's that would be the same if it was used in health, physical, physical health or mental health. Yeah, I feel quite strongly about that (Lived experience)*

We also heard that definitions of capacity need to be aligned across legislation.

> *Yeah, I mean, I kind of agree with what [name removed] said about the decision-making capacity in terms of you can use that the same as you use for you know, people with dementia or I know in some cases children who want to make decisions for their own care? (Lived experience)*

We also heard that new mental health legislation should require capacity to be reviewed at regular intervals. Such flexibility is important as it acknowledges that the individual may demonstrate decision-making capacity after a relatively short amount of time. We heard that, at a minimum, capacity should be an integral component of the assessment process.

> *Often decision-making capacity is a blanket thing and it's sort of done. Whereas from my lived experience, decision-making capacity can wave in and out, and sometimes quite quickly. I could have decision-making capacity in one moment and then six hours later, I wouldn't be in such a great space, and then another six hours later back again. (Lived experience)*
>
> *Yeah, I think flexibility. So one, give people time to make decisions to allow people to change their mind as well. You know, like, I would love it. If I when I had entered the services, if I'd been given more information about the potential options for treatment. I was not given any options for the treatment. And in hindsight, I think some of the treatment was, like a waste of time, you know? So yeah, and then the ability to be like, actually, this treatments not working for me, can we look at or revisit other things, you know? (Lived experience)*

SUPPORTED DECISION-MAKING

From those with lived experience, we heard about the impact of privileging a western-biomedical model erroneously positioning psychiatry as a single and dominant authority.

> *When someone else's saying thing, going, That's too risky. And we're going to stop you from doing that, where each person is acting out of a set of values and beliefs. But they're prioritizing stuff. And you know, they might have stuff in common, but they're prioritizing them in different ways. And the person with the power, the psychiatric team, that often the psychiatrist is the one whose vision in viewpoint instead of values are the ones that take precedence. (Lived experience)*
>
> *Psychiatry is one lens, you know, it is one lens to look at these experiences through and people have recorded, you know, all kinds of different ways of viewing what it is they're experiencing and why they are in distress. Capitalism, colonialism, there are so many big systemic influences on distress that land unevenly on certain populations on individuals. Psychiatry is a western, privileged, you know, all those things. So like it dominates too much. I'm sorry, that won't be popular with a lot of a lot of people but it slowly dominates too much and it shouldn't. That's part of the problem. (Lived experience)*

People with lived experience stated that supported decision-making recasts the needs, perspectives and wishes of tāngata whaiora as the focus of health responsiveness. We note that some lived experience stakeholders referred to this as supporting a relational mental health system. We also heard from those with lived experience that this shift requires the provision of time to meet with the individual to discuss the individual’s needs and preferred treatment pathways.

> *But it is the person that we are, you know, it's an individual. And, you know, the question, clinicians are not at the centre of the circle, it’s the individual. And so, just making sure that we get that right, it’s a new model, where it's not up to, you know, the clinicians move on after six months. I mean, realistically, especially in Wellington, they're going on a rotation every six weeks. But when the clinicians move on that person's left there and they need to be the centre in, and the others, employed by them, basically, you know, so people need to be given that respect. (Lived experience, disabled person)*
>
> *So how I would want to be supported to make decisions, I would want people to take the time to know what's important to me, what I value, you know, how I might be prioritizing things in any given minute. They might have to gently remind me that actually, you know, most of you, I've known you for 40 years [name removed], and actually usually this is the way you would have those priorities. So there might be some gentle reminding of who I am. And other times of my life. So the point about this, I think it feeds into a relational mental health system that really takes the time to get to know people. (Lived experience)*

> *I like that definition. It seems quite similar to the other ones I've seen in other countries, or people have shown me, I think it's, as I was talking about that fusion thing, it's, it could be the same, you know, Alzheimer patient or, or someone who's just had a stroke, or whatever it could be used, the same should be the same for all, everybody who can't make a decision. And I think, though, that adding in the ability… well, even if they can make a decision, people usually like to have some support behind them. I mean, I do if I'm making decisions, I'll usually ask my family for help. But that's a slightly different from this, but yeah, not really, I think there should the person involved should think about who should help them. And I think the whānau, if they don't know, who, you know, hasn't really expressed anything, then I think the whānau should be the ones involved. (Lived experience)*

It was mentioned that tāngata whaiora should have the right to include those most important to them in these planning discussions. We also heard that cultural advisors, peer support workers and advocates need to be included in the process, and that supported decision-making, and ensuing plans, should be a legislative requirement. We heard that the inclusion of clinicians, whānau or significant others and independent peer advocates would provide a balance between clinical and lived experience knowledge.

> *I guess one of the things that I would think about is I know you had in there, the ability to co-decide with a doctor. I know there have been massive requests from the mental health community to have more peer support. And I am concerned on some level that a lot of what we're talking about here is still the medical model, and to factor in the opportunity to have decision-making ability from somebody with lived experience or a peer support person, because they will bring a different perspective. Yeah. And so I guess that's maybe not so much about not having doctors or psychiatrist involved. But also having somebody who does have lived experience weigh in on those decisions as well, so that you get the balanced perspective. (Lived experience)*

> *As an autistic person, one of the problems that I have is when I'm in meetings with people, at the time, my decision-making and what I'm thinking and my ability to process information is very impaired. And people often don't realize how impaired it is. And so they take what I'm saying there and then, but actually, I need to go away and discuss those things with my family and people that I trust and just to have time to process the information, write it down. And then I've, when I've had that time, and that opportunity to do that. But always what's happening is, when I'm in the meetings, they are taking what I'm saying, which is usually nothing to do with what I actually want to do and feel. And it becomes very confusing. It confuses the conversation. So time for processing information in the way that works for the individual as important as what you're saying, (Lived experience, disabled person)*

Within this context we heard that family or whānau is essential.

> *Let's change the language to that we have, [to] that we have hui and a wānanga. And that we you know, there's a talanoa this and then it's not about it's just about that setting that we have. And as Pasifika as Māori. It's a collective. It's not just the clinician/doctor at the time, the tāngata whaiora are those two over there like that, inside the meeting inside the little small office, it's actually collective perspective. And then also with whānau, being able to strengthen whānau capacity to be able to do that decision, particularly when…. I'll give an example. So when I wasn't, I was very unwell. And it was my I did manage to tell my sister what I want to my sister told the doctors and things they didn't listen, I didn't listen to me, and they didn't listen to my whānau. And that's why I want to get all the mana to tāngata whaiora and family and Iwi, and because it's not just a smaller group of us .. there is my aunties and uncles if they knew they would come and help me. So that's my version of supported decision-making. (Lived experience, Pasifika)*

> *I guess that's the other thing is that the whānau should be involved if they do have reduced capacity. Who's gets to decide? Well, I think that the family should be involved in that as well. Yeah. (Lived experience)*

Participants said that mental health legislation should acknowledge that the wishes of tāngata whaiora about the inclusion of family or whānau should be paramount. We heard that this is important because it cannot be assumed that all tāngata whaiora have a positive or supported relationship with the family or whānau. We also heard that mental health legislation should explicitly state that provision for significant others, as defined by tāngata whaiora, to be part of the decision-making process.

> *Obviously, I know, I know, some people are feeling traumatized by their own families. And, of course, in that case, you shouldn't have them involved. But I think the default situation should be that the family and whānau are the ones who were told that there's a problem, you know, and asked to help with supported decision-making. (Lived experience)*

> *Family does not just mean blood relatives, that being friends as well. (Lived experience)*

In addition to including significant others and peers as a means of developing and implementing holistic responses, we also heard that independent support for tāngata whaiora is essential to the individual's protection. In this regard, we heard multiple accounts where tāngata whaiora were asked to sign mental health documents without understanding what they were agreeing to. In response, those with lived experience stressed the importance of mental health legislation requiring provision for an independent advocates and cultural support kaimahi to ensure tāngata whaiora understand what they are signing and intervening in the event that better explanations or an increased amount of time is required before the individual makes a written commitment.

> *Yeah, they're like. "Sign here". "You can't read that document? So don't worry, we'll just give you a quick summary. And you can sign." (Lived experience, disabled person)*
>
> *Forcing you to sign on the spot to is the wrong thing to do. Because I couldn't process that information. And I came away feeling like actually, I was forced to sign that. (Lived experience, disabled person)*

We heard caution over assuming a mental health professional is sufficiently trained, and has an adequate understanding of holistic models of wellbeing, to be able to make a decision. In this context, it was emphasised that any decision-making, where capacity has been determined to be compromised, should occur through collective decision-making, inclusive of wananga, that include: mental health professionals, whānau and friends, and peer support workers. It was also raised that advance directives are essential in these situations to ensure the individual's wishes are held as a core consideration.

> *You know, a credential. Like the Japanese have these psychiatrists who are supposed to be the ones who can make decisions and they they're just beholden to the hospitals and they just they just throw everybody in restraints, no matter what. And I'm not sure … how the credential would be credentialed. You know, it's really hard to know on that scale, but I do think getting, I think maybe the answer is to have more people involved, you know, the whānau to know, they can sort of give an idea of what the person used to be like, and the Advance directives if given them before, and, and their friends, you know, I guess I think it's fine. But you know, people who really know the person and peer supporters, to have a range of people, not just one person to make the decision. So it, it has to be, you know, it's a very intensive thing to make that decision. And so I don't think it should be made very often. So you it ought to be done with a lot of people involved before you can take away somebody's ability to make a decision for themselves. (Lived experience)*

Advance directives

Lived experience participants strongly suggested that the use of advance directives should be embedded in the legislation and that the use of advance directives provides tāngata whaiora with greater autonomy which is fundamental to a person's wellbeing.

> *The place for advance directives is something that I'm really interested in seeing. And okay, especially from like, my lived experience point of view, and this has been, you know, just really kind of personal, my own interests and what I want to be able to do to safeguard my future is to be able to make those decisions for me, when I am well, so when if something doesn't go so well, in the future, I know I can have my wishes and decisions honoured as I would want them to be. And I think it's that, you know, that balance also acknowledging that people are allowed to make bad decisions, or decisions that we disagree with. So how do you kind of acknowledge and balance that because often, within Mental Health Act framework, there's such concern around risk*

> *and safety that we also forget that people are allowed to make bad decisions, or [what] others see as bad decisions. (Lived experience, Māori)*

While the provision of advance directives exist, they remain underutilised. We heard that lack of uptake of advance directives can be attributed to clinicians who fail to see the utility of the directives, a lack of knowledge amongst tāngata whaiora about their existence and a reticence informed by others' experiences of having had clinicians override the advance directive.

> *Because some people with a lived experience basis, they will, they don't have advance directives because they've just seen them stomped on for other people. (Lived experience)*

We heard that provision for the development of an advance directive should centre on the needs and wishes of the tāngata whaiora and that the tāngata whaiora have the legislated right to support and develop an advance directive with a range of people who will assist tāngata whaiora to develop a directive that addresses their holistic needs and wishes. We heard that holistic perspectives should include: cultural advisors, clinicians, legal experts, significant others, whānau and family, and peer advocates.

> *Participants related that the individual's wishes, as set out in an advance directive, need to be safe guarded. We heard that there have been multiple occasions when an individual's wishes under an advance directive have been overridden by the clinician(s).*
>
> *Advance directives are very important. They've been around forever but a clinician can override it. And technically, they're supposed to explain why they have overwritten it, but it's so tokenistic, what they do is so minimal. So I think advance directives could be used to good effect, and it needs to be a much higher strengthening that it's overridden by a clinical team, then there has to be an inquiry to question why do you think your values needed to dominate when this person clearly expressed that they wanted to stay at home surrounded by whānau, to be treated with Māori medicine or principles? Why did you override it? And is it okay, so I think it just needs to get more teeth. (Lived experience, Māori)*

It was raised that there should be no situation when a sufficiently resourced and holistically informed advance directive can be overridden by a clinician.

> *I think if you did your advance directives correctly, there would be no reason to override them. So you are asking that person I never got asked for advance directives either. And I can understand why not I was in the system for a long time. You had plenty of opportunity if you know, my situation could have escalated to the point where I needed them. I was never given an opportunity. Again, you know if you put on your advance directives, alternatives for like, if whatever you've put in your advance directive is not working, you know, who's the next point of contact you would like to have make decisions with you. And then you could nominate a person, whether that be*

> *a parent, your partner, a medical practitioner, that you do trust, who you think knows you, you know, if my advance directive is not working, and you want to change my treatment, you can only do so after consulting with this person, because I know they know my story and have my best interests at heart. And to me, yeah, if you've got those things in place, I struggle to think of a reason why you would override the directives. (Lived experience)*

We heard that there is an urgent need to develop a national system for storage and access of advance directives. We heard that the creation of such a system should be included in mental health legislation.

When there is no advance directive

Participants described situations when an individual with no previous mental health diagnosis suddenly experiences a sudden acute mental health crisis. In situations when there is no advance directive, we heard from those with lived experience that legislation should require clinicians to enlist the perspectives of the individual's significant others as soon as practically possible.

> *Well, as a family again, it would be the first I mean, like, of course, you ask first person, you do the de-escalation and all that first, and then find out if there is anybody that they want to have help them make a decision? I think that would be the main thing, the first thing you try to do that if you if you can't, if they can't say that, then you try to get the family involved. Yeah, I don't know if you can't find a families or friends. I guess there has to be at that point, some kind of somebody else.*
>
> *No, I don't I don't think I've ever met someone who has lost 100% capacity. I just think that's ridiculous. So I think, just because someone hasn't got an advance directive doesn't mean they don't have preferences, (Lived experience)*

It was emphasised repeatedly that if a person experiences any form of compulsion or connection with services best efforts should be made to draft an advance directive before complete discharge.

RESTRICTIVE PRACTICES

Reduction or elimination of restrictive practices

From the majority of those with lived experience we heard that restrictive practices are draconian, barbaric, and akin to torture. We additionally heard that restrictive practices almost always unnecessary in inpatient settings.

> *What rings true is that restrictive practices are barbaric and draconian and are not needed within inpatient centres. What is needed is kindness, compassion and empathy. And actually just having a listening ear, and actually just understanding the drivers of one's behaviour and why we are reacting to situations. (Lived experience)*

So I think that yeah, putting people in a room by themselves is torture too. And, in fact, it's been shown that people get mental health problems by being put in a room by themselves. And so why would you put someone with a mental health issue in a room by themselves? You know, why? Why are they in solitary confinement? I think that's completely unnecessary. (Lived experience)

I just got a feeling that they might be put in a more complicated and more stressful situation. Because as far as I'm concerned, this system, the way [it] works feels like treating, treating young babies by doing a time out. They do this to mentally uncomfortable people. They do it the same way. Why I don't like this is, if they are really playing tantrum like spoiled child, they should be put in a timeout. For some people who are very self-conscious. They know what is going on in their life. But they are frustrated and they don't know how to get out. Timing out, like putting them into a respite or even an inpatient clinic without more support could, if they are not strong enough, they may… I don't know. So this is how I felt, but may not be relevant to other people. But I felt it is not warm enough, because I do believe that mental health can be healed by love and support, instead of being very stern. Only for those serious cases, if it is very difficult to deal with, like if people are substance abused, they lose their conscience, or they could be treated in different way. Yeah. (Lived experience, Asian)

It's interesting. I like that analogy of time out. And that sense of one of my challenges is around a time when we most desperately need connection, we the taking people away from the connection, we desperately need to feel grounded, we take us away from spaces that may maintain grounding. And for young people [name removed], one of the things that I heard was the removal of a young person's cell phone, and the impact that that has on connection for them to the world around them, but also to the loved ones. Some people need space from their loved ones, but it's around how we navigate that, right. So the timeout, analogy is really good. It's like we create a disconnection when people need a connection. That seems a little bit back to front. (Lived experience)

Someone to even just having somebody in the same room as you I mean, even if it's like a healthcare system or a peer support person or the chaplain, because, like, then at least you've got a distraction. Like I said, I was there because I was unable to manage what was happening for me. And my situation was even worse, because I was in in this room with nothing to distract me. You know, it's like, this is not right. Like, if I have someone I could just had basic conversation with, it would have been a starter… this is what best practice is, is going to be the least distressing for the person that is making sure they have peer support, that is giving them something to do maybe in that space. I don't know what you're going to give them to do. But you know what I mean, like just sitting there for hours on end idle. I didn't even have like coloring pens or anything. You know, what, it made me worse, not better, like I said, to the point where I acted out. And then of course, I got attention. But like, that's not, you know, it's

> *not helpful that now my record is, however much more severe than it needed to be like, yeah (Lived experience)*

Those calling for an end to restraint and seclusion stressed that person-centred practices would prevent the escalation of emotions and response to the point of intervening with seclusion or restraints.

> *And then of course, the, the whole point is to not get to that state. If you start talking to people early on, you know, if you have advisors, you know, somebody's really talking them down, really listening to them, and trying to help them understand what's going on, they'll be a lot less likely to go into getting violent in the first place. (Lived experience)*

We also heard of multiple examples where zero seclusion practices have operated successfully. These examples were shared to reinforce the need for mental health legislation to explicitly exclude seclusion as a practice and instead placing emphasis on the use of de-escalation and modifications to the environment.

> *And again, I think there has been some successful models where they've had zero seclusion. And so you know, we have demonstrated in areas that it's not needed, there are other methods. So just go with zero seclusion, basically, you know, if we've already demonstrated that can work in places, and we know that it's traumatic for people. Why are we still doing it? (Lived experience)*

Caution over definitions of seclusion was shared by those with lived experience. Participants stated that mental health legislation must clearly define seclusion and seclusionary practices, as vague definitions have enabled seclusion while not meeting a clinical or practice definition of what seclusion entails. In this regard, we heard that seclusion has “operated by stealth” within our acute mental health wards whereby the use of chemical restraint has operated “under the radar”. We therefore heard concern that caution should be exercised that the removal of seclusion and physical restraint does not result in increased use of chemical restraint.

> *Yeah, and I do think that we need to consider all of those restrictive practices by stealth, and again, make it harder as part of their culture change, how do we legislate to make it really, really tough for people to use restrictive practice? How do we put the burden back on those doing those things? Just to make it not the default to make it really tough? (Lived experience, Māori)*

> *But what happened was I ended up coming in half an hour after I'd taken a massive dose of tranquilizers and dragging me out of bed and physically gang of people, restraining me and dragging me down the hall with my breasts hanging out everywhere on a sheet and being locked up in seclusion. But it's not even recorded as seclusion. Because they've, they just have decided that if you're in a seclusion lounge, with a staff member, no matter how aggressive or intimidating they are that's what if they put a staff member in the because the Ministry of Health sees seclusion as when*

> *persons on their own. So this was a seclusion incident. It was nothing but a seclusion. I was locked up for five hours away from other people, but it's not even recorded as seclusion. (Lived experience, disabled person)*
>
> *They twist it up all the time. And forensic wards my first consumer advisor roles on with a forensic services in Canterbury standing night orders was an issue then. They're still an issue now 15 years on. Seclusion technically has three elements. And so that example, I can show you with the two of them off the top of my head, but the example you're giving it is they do with standing orders, they say, actually, not all three conditions are supposed to meet the four technically doesn't. And we don't have to record it yet. (Lived experience)*

Participants mentioned that restrictive practices have been used as a preventative de-escalation practice. In this regard we heard that legislation should explicitly prevent the preventative use of restrictive practices.

> *Sometimes we talk about it being last resort, but sometimes it sounds like it's actually prevention. And I think maybe, possibly one consideration is around actually naming that this can't be used as prevention. It needs to. Yeah, like [name removed] was saying that someone start hands[raised] and start to come towards someone's throat. That's quite different between someone just refusing not to go to bed. (Lived experience)*

In regard to the use of restraint, it was emphasised that new mental health legislation should actively exclude the use of mechanical restraints. We heard support, however, for the rare provision of the individual being physically restrained in situations where the individual might be actively trying to hurt themselves or someone else. We also heard that legislation should explicitly state that the individual should be free from restraint as soon as they are no longer actively attempting to hurt themselves or another. It was stressed that such time-related sensitivity requires consistent monitoring and that such monitoring should occur in tandem with an independent peer support advocate and significant other as part of the decision-making process.

> *Again, the peer support because I think it's very easy for staff to all collude and agree especially like I said, when they thought that medical model training you know, if we ask You need to have a family member or a peer support or somebody who's not part of that medical model that agrees that this was a necessary course of action, I do have friends who have been secluded. And when I hear their version of events, I struggled to understand why any of that seclusion was necessary. You know, my two friends that have had seclusion are both females, they're both not strong, you know, like physically strong, aggressive individuals, you know what I mean? You know, it definitely would have been other courses of actions that could have been taken. Yeah, all I can imagine is that healthcare workers are either short staffed and don't want to deal with it, or they were emotionally exhausted themselves. And we're just like, I can't*

> *deescalate these situations, I'm just going to put the person you know, in a room sort of thing. So yeah. Again, I think there's a lot of other techniques you could use. (Lived experience)*

From others with lived experience we heard the use of restrictive practices should be a last resort option and that last resort should be clearly defined in mental health legislation.

> *Yeah, that's the problem with saying we're trying to minimize it and it's of last resort. I mean, that's in the [overseas] laws, too. You know, they look like they're great laws, you know, only use it as a last resort. But it becomes the first resort. It's really in their practice, anybody who comes in and, you know, anybody involuntarily brought to the hospital immediately gets put into mechanical restraints in many hospitals. Right away, they put in room by themselves, tied down, can't do anything that's supposed to be treatment. Or it's supposed to be a last resort, but they haven't even tried anything.*
>
> *Yeah, I think that's one of the ones was focusing on legislation so much as well. I'm supportive of there being legislation, but a lot of it comes down to interpretation of that legislation. Right. (Lived experience)*

Environmental and workforce considerations

Participants strongly suggested that that practices of seclusion and restraint would be greatly reduced if a number of environmental and workforce considerations were appropriately addressed. We heard, however, this would require a major shift in the way that those with mental health challenges are supported.

It was noted that appropriate engagement with tāngata whaiora and whānau is essential to a model of care reflective of mana enhancing practices. We heard appropriate engagement practices are vital and guidelines should be included in the new legislation when an individual is admitted to an acute mental health care facility.

> *Whanaungatanga and tikanga Maori, is the way to go to prevent restraint and seclusion. (Lived experience, Maori)*
>
> *Yeah, like bringing manaaki, manaakitanga and really upholding the mana of the person… yeah, connected that with the whanau through whanaungatanga. (Lived Experience, Maori)*

Those with lived experience stated that clinical settings need to be adequately resourced. We heard that restrictive practices are enacted because of inadequate staffing. We also heard that such enactment is more likely to occur outside of regular working hours and in weekends when it is more difficult to access peer and cultural supports. It was stressed that new mental health legislation should provide for adequate staffing, peer and cultural support outside of regular working hours.

> *Staff will often say, and consumers and reflect this, it's when they're short staffed, under resourced, too many people, you know, stuff like that. Yeah, a lot of it comes back to resourcing as well. (Lived experience)*

> *So yeah, and another thing I heard about and I was getting, there was saying to have open, like the nursing wards are kind of closed, and you have to knock on the door to get their attention. So I noticed this when I was visiting my son, you couldn't, nurses wouldn't answer when you knocked on the door, I had to go out because I was not the patient. And I could go tell the guard that I needed to talk to a nurse. And they would say, Well, why don't you just knock on the door? Well, no, the nurses weren't answering it because, "oh, well, I thought you were the patient wanting to go out for a smoke". You know, so they shouldn't be allowed to just keep themselves closed in like that, then they would know what's going on all the time and they'd be able to see and help before things start to escalate. They can, you know, jump in and help somebody is starting to have issues. (Lived experience)*

> *Yeah, [name removed]. I mean, it kind of feeds into what I was saying before about, like, when I had my first hospital experience, and I had no idea what's going on, the only way to get attention or help from anybody was actually to act out, you know, and those nonresponsive nurses, you know, I mean, that is the situation. (Lived experience)*

Acute mental distress and substance use

Those with lived experience described a degree of uncertainty in regard to the use of restrictive practices for those experiencing substance-related unwellness, namely they were unsure of how to minimise trauma while affording the individual protections.

> *But then again, if you had somebody who came in high on this, you know, maybe that's the only thing you can do with that person in that situation. So, yeah, it's tricky. (Lived experience)*

Monitoring and review

We heard from those with lived experience that legislation should embed safeguards where the onus is placed on mental health professionals to demonstrate the need for the use of the restrictive practice. We heard that such burden would provide one level of protection and this protection should be included in new mental health legislation. Participants strongly suggested that legislation should require mental health professionals to evidence efforts to de-escalate had been attempted before seclusion or restraint was exercised. The spirit underpinning such requirements reinforces that seclusion and restraint is a last resort and that legislation should safeguard against the overuse of such practices. Integral to such safeguards would be a requirement to report such incidents.

> *I think it's really important to have concrete evidence of if you're saying why you did what you needed to do. That was one of the things with, my son in the overseas system, they had every eight hours, they had to say why they needed to stay secluded. But all they said was the same thing. Every time. They just said this person's out of control. And they didn't say why they said it was out of control, what they were doing. The nurses notes, at the same time, were saying, Oh, he's saying thank you,*

> *and he's acting nice, and he's calm. And then the statement was there two minutes later saying that he was out of control. And it was the same statement every eight hours. So I think you have to make them explain exactly what's happening and why it is that they need to be done. And then yeah, with the patient, talking them over also with the other staff, you know, what could the other staff have done to make it better and try to improve continuous improvement? (Lived experience)*

We also heard that legislation should protect tāngata whaiora and the duration the individual experiences restrictive practices needs to be reported to an independent body and alongside clinical justification.

> *I don't know how qualified I am to comment really on seclusion and restrictive practices. I mean, I know there's been some kind of push to have like zero seclusion, and it's been successful in some places. So I would push for that. I think in the situations where it is used, I guess, having regular review, I'm not sure what the current, you know, what the current criteria, but you know, the idea that you could just put somebody in seclusion and leave them there, and like, maybe come back four hours later, you know, like, it's that to me is not okay, a person's situation can change a lot in four hours, as we talked about before, you know, people's emotions are going like this, the rationality, their ability to make decisions for themselves. You know, so yeah, I think if you are using seclusion to use it to its minimum amount of timeframe as required. And, you know, they would have to demonstrate that they've had, that they have used it to the minimum amount of time. So whatever kind of checks you need to put in place to have that that happens. (Lived experience)*

We also heard that legislation should require any restrictive practice event to be reviewed "quickly".

> *If we're going to keep some, then there's got to be a huge amount of effort going into reviewing every event in quickly, like as it's happening, so who was it she was on the ground as it was happened to be part of an inquiry starting? (Lived experience)*

Those with lived experience suggested that legislation should require organisations to engage in follow up/debriefing processes with tāngata whaiora who have experienced restrictive practices. The spirit underlying this process would be to assist tāngata whaiora to address possible trauma arising from enlisting restrictive practices and to develop a strategy to avoid enlisting such practices in the future.

> *And actually, I really believe we've got a unique situation in New Zealand with the Māori system of restorative justice. And I think that should be incorporated into this, there needs to be an end or an after thing where people can all go and restore some trust and faith. Because it hasn't happened for me. (Lived experience, disabled person)*

> *And so the rest of the time I was in there, there was no treatment or anything because I was so affected, I've been so affected by this event was one of the things that I shut down from them and I have so the whole last three months or whatever, that I've been*

> *there since then that has been torture for me. And I felt like that event it was so traumatic, and then I've just been traumatized and trapped in the service. So it's really important. And I think that one thing that could be included, if a situation did happen, where whether it was right or wrong, or by any kind of thing. I think that a restorative justice type process. (Lived experience, disabled person)*

PROTECTING SOMEONE'S RIGHTS

We heard from those with a lived experience that the Mental Health Act has resulted in the continued erosion of their rights. It was further mentioned that they have had no significant or efficient recourse and described current provisions, such as district inspectors, are ineffective in light of their lack of independence.

> *And there was no protection, no systems under the Act, the like the protection, the only really protections that you have when you're under the Mental Health Act is the District inspector, and an advocate. And those systems are not working. You know, like I because basically, you have to ask a nurse to see a a district inspector, and they just don't pass the information on I actually had to go to [Name removed] on the outside because of my networks. He actually ended up through Wellington and through his networks, basically telling the district inspectors, they need to go and see me because it was just being denied all the time. And partly the district inspectors, I think [they] know that, that what they're doing is meaningless, and it's not working. So they just don't the heart is not in it. (Lived experience, disabled person)*

Ensuring tāngata whaiora and significant others are informed and understand

We heard about a high degree of confusion amongst those with lived experience when they were placed under the Act. We also heard from those with lived experience of not knowing what their rights were. As a consequence, we heard many accounts of feeling confused, powerless and traumatised. Tāngata whaiora emphasised their right to be fully informed and that this right, and stipulated processes of communicating those rights, should be included in new mental health legislation.

> *I was never, I was never given my rights, even as a patient. And I have never seen them anywhere advertised when I was a user of the services. So you know, as a first thing, can we let people know their rights? (Lived experience)*

> *I did actually write a letter of complaint at some point, which I never got a response from. I was not aware that there was an official complaints process. And I was not aware that, you know, if I had have gone through the official complaints process, I would have had to have got a response within two days. The fact that I sent a letter to the services, and they didn't bother to tell me that is an official complaints process, which I can go through, you know, we're not doing basic things to uphold people's rights. So, yeah, that is a massive amount of improvement. (Lived experience)*

> *Yeah, I think, you know, there's sort of two aspects of this one is what do you do for specific for people? You know, what is the first like, can they make a complaint. I do recall seeing, I might be wrong, but I recall seeing some things on the walls in the mental health area. And actually, when I go into the regular hospital, there's always something saying that you have the right to complain. But maybe that was that was that raised you were there? (Lived experience)*

> *The first thing is I certainly believe it's very important, but then the challenge is people also need to know what your rights are. Maybe I think a lot of Asians and migrants, probably not too sure what their rights are. And that's why, that is the conflict. (Lived experience, Asian)*

We heard from those with lived experience that significant others, including family and whānau, are often confused about the Mental Health Act. It was noted that significant others are often not aware of their rights or the rights of tāngata whaiora. It was raised that significant others have the right to be better informed and that this right and the right to have information provided in an easily understood manner should be included in mental health legislation.

> *So around making the communication accessible is a big thing. And also the information you're being handed. So if you're handing someone a piece of paper, does it make sense? What's on the piece of paper? Can they read that piece of paper? For me, don't hand me paper. Paper is useless in my situation. So you know, what, looking into accessible formats, whether that's a simplified format, or written communication, just even emailing the information. Because you know, you get into these places, you come out with a big stack of stuff and numbers to call and information about your medications or anything like that. Can it be emailed so that it can be used in an accessible format, audio, or screen readers and things like that? Also, you kind of get bombarded with everything and expected to remember it and process make a decision or go away process and make a decision. And remember everything. So are you allowed a person there that can take notes independent of the doctor or the, you know, the provider? Can you have a support person there who can ask questions on behalf of you? Can you have a nominated person or an advocate or peer support worker that's provided as it isn't somebody that you could nominate from the family or whatever? To keep that going, um, would be my thinking. And yeah, the in clear some clarification around some of the jargon, there's a lot of jargon. And I can see it as a few should know these things already. And often, you don't because it's the first time you're hearing them. And that's a big thing, too. Or you get a quick explanation, but it's not in-depth. Yeah. So yeah, that that would be a big thing. I think. And something that yeah, the someone who can take notes for you definitely. (Lived experience, disabled person)*

> *I just wanted to add to that comments There are nine different languages that are Pacific languages in New Zealand specifically acknowledged. We need to*

> *acknowledge all of those, including Māori. All documentation, so not just consultation documents, the full documents, anything else that supports information around that. And the reason I say that is because you know, taking Māori things as well as the Māori language, much like Pacific languages, beautiful languages. Because they are just so much more descriptive. What I need the Ministry to understand is that if we want our people to engage, and need to have then pieces of paper with information with brown people that are dressed up, like we dress, we've got to see ourselves in something before we even want to look at it, pick it up and then process information and engage anybody. But actually, if we want to get this right for our people, this is where its starts that before its even put together. So acknowledging there's a lot of people that aren't necessarily pacific going to be working with in this space and on this. And I thank you for your service to our people because its not bloody easy. (Lived experience, Pasifika)*

Burden on clinicians to demonstrate the rights of tāngata whaiora are upheld

Those with lived experience described how the Mental Health Act has been misused by mental health practitioners and this had resulted in significant levels of trauma amongst tāngata whaiora. We heard that burden should be placed on those invoking mental health legislation to demonstrate the individual's rights are being upheld. Such burden would provide one level of protection and this protection should be included in new mental health legislation.

> *If there's going to be legislation, and as part of it, legislation about putting the burden on the people invoking the Act, to prove that people's rights are being upheld, and rather than just thinking of how do we check? How do we actually prove either beforehand, or as part of the process? How do you put it in there so that it's rigorous and that is not just a checkbox? So I have like, just personally all about the rights kind of thing, how is that actually, you know, a, that as part of the process that a tāngata whaiora has access to an independent peer based consultant to work through and check out with them, but yet their understanding of all of this process, and they feel that their rights are being upheld? Or not? And in-depth submitted as part of the process, so, like, making up something but yeah, how do you actually have something more rigorous than that in there (Lived experience, Māori)*

> *I had the great privilege for three or four years of being heavily involved in de-escalation training, at Canterbury DHB. And we wrote our own program and then lead quite a bit of that, which was phenomenally progressive of my colleagues, we always did a section on values, including the, at that stage, the inversion of let's get real from Te Pou, which at that stage had human rights as one other kind of key six things that were part of the approach. And when we did that, did an exercise with staff around that. Invariably they've named all the other five things organically out of their own priorities and understanding of things and human rights was always left off, and then would sort of remind them, , I think it's really misrepresented, misunderstood just as*

> *left off. People aren't reminded enough what a huge responsibility they have when they override human rights. So yeah, I don't know the answer. But I just wanted to name that. (Lived experience)*

> *Again, coming starting from a place where mana enhancing practices is understood as a given would go a long way to getting us in the right direction. But again, that's a paradigm shift. I don't think you can graft it onto what you've already got. I think we're just going to end up with it with an uneasy compromise in lots of self-justification after the fact. (Lived experience, Māori)*

Holistic support

We heard that the wellbeing of tāngata whaiora can be protected by ensuring their wishes, needs and perspectives are a central consideration. We heard that incorporating the perspectives of cultural advisors, clinicians, legal experts, significant others and independent peer advocates can afford tāngata whaiora one level of protection. It was stressed that this protection should be included in new mental health legislation and that inclusion requirements should be clearly stipulated in new mental health legislation.

> *So they have to, they have to go and write off the whole of the next day, to spend the time on the marae, talking to all the people that are I'm thinking, open dialogue, that kind of network, meaning where all the voices at the end are prioritized equally, because I think we put far too much value on the expert opinion of one psychiatrist. And it's not actually safe for them. It's not good for them, either, because they're the ones who then feel that whole sense of responsibility for outcomes. And it drives a paradigm where I'd rather see a shared responsibility for outcomes. That seems more respectful to people, to all people. Yeah. (Lived experience, Māori)*

> *Absolutely. And as part of that power sharing, because I know you know, mental health professionals, we've got all of it's a lot to put on us. It's like, okay, well, let's not put that all on you. Let's give some equal power to creating and facilitating that process. (Lived experience, Māori)*

Participants stressed the importance of new legislation clearly describing consultative partners, inclusion processes and how various perspectives will be safeguarded. The need for clarity can be appreciated in light of participants' past experiences of family and whānau consultation. In these situations, consultation occurring under the Mental Health Act was described as "tokenistic" and mental health staff were described as treating consultation as a "compliance exercise" and not a foundational requirement.

> *The problem is their current Act says, oh, we'll go and consult with whānau, and you know, a psychiatrist can easily sign that off as a phone call, or I know that phone call was too difficult to make at one in the morning, or whatever it is. And it's like, well, you know, if we just keep putting this kind of stuff in the Act, we're gonna keep getting the same results. So how do you actually flip it around and make it too hard for whoever is doing? What are the processes to not do that. So that actually, you know, they can't*

> *go, they have to, you know, go through this whole application process of whatever it is or to, you know, to override an advance directive that they have to apply to whatever body it is, and they have to engage with us, you know, with this peer support service, and with the Iwi service, and they have to do all this stuff before they can do this. And they have to have that documented. So if you're really gonna kind of go with the Act, how do you make it really hard for people to do it? (Lived experience, Māori)*

Independent peer support advocates

We heard from those with lived experience about the protections afforded by independent peer support advocates and that these roles should be funded, made universally available and embedded within new mental health legislation.

From those with lived experience it was mentioned that independent peer support advocates are needed to act as a conduit between tāngata whaiora and health staff to assist communication between tāngata whaiora and health staff, to advocate for the needs and rights of tāngata whaiora while effectively preventing the development of poor relationships between tāngata whaiora and health staff; what we heard referred to as "hostility".

> *If there was peer support workers, that acted as a bridge between staff and patients and their families, that the sole purpose that they were there is to develop rapport, because the hostility that develops and the constant battle to get your needs met all the time, creates a horrible, hostile relationship that is not therapeutic. And if there was peer support that was solely there to develop rapport, and to help communication processes and to act on your behalf, and to make these processes simple, so you're not battling that this experienced peer support, people could be writing collaborative notes with you, sharing the information, because at the moment, the way the nursing staff is, is that all the nursing all the information that goes to the clinicians, and any problems that I have goes through the nurses, but they actually, this is literally the contact you have with the nursing staff as they give you pills in the morning and take it your obs. Yeah, and they give you pills at night and take your obs. Yeah, they have no contact, no time, no interaction. There's no time spent developing relationships and rapport and trust and anything like that. So any nursing notes that are going to the clinicians were made up because I had no real conversations with nurses. And having the peer support during collaborative notes and purely developing relationships and conversations would put a huge dent in the accessibility, you know, and all dealing with all that stuff. (Lived experience, disabled person)*

> *I have seen it in the in the physical health hospital, I have seen the posters, I did not see them in the mental health space when I was in it. And again, I was in such a vulnerable state that I think I would really have liked to have had someone be the advocate for me, I didn't have an advocate, my overall experience is that people that do have an advocate tend to do better in the services. So they have a family member who can come in and act on the other half, you know, and fight for the rights they tend*

> *to do, but I didn't have that person. And I just yeah, it would have been great to have known that. I think the Health and Disability Commission can provide you with an advocate. But again, I was not made aware of that at the time. (Lived experience)*

> *I'm surprised that in all of those slides, there isn't any support or any mention of peer support, I guess. And given that I know that the mental health community is so anti the medical model, that it doesn't come up as a potential option for change is where can we use people with lived experience and peer support? And I would love to see some of that legislated for, I think is a massive need for it. And that doesn't mean getting rid of the medical models. I think it has its place, but it needs to be they both need to be used, you know. (Lived experience)*

An independent review body

Those with lived experience strongly supported the creation of an independent review body with a specific focus on the human rights of tāngata whaiora.

We heard from those with lived experience that there is a need for an independent body because experience has shown that internally reviewed complaints are not free from organisational or professional bias.

> *This is the thing, the result of the complaint is because processes and the legalities of the complaint system, they deal with it internally. So they basically come back and said, it's terrible, it shouldn't have happened, or we've talked about it, and we'll make sure it doesn't happen again. And it's happening all the time. And there's no accountability, none of the staff have been sacked because they made really bad decisions that actually were very traumatic for people, for me, and none of the processes. These should all be covered under any kind of legislation. (Lived experience, disabled person)*

Participants suggested the need for an independent body because existing mechanisms, such as district inspectors, are "seen as an extension of the existing system rather than a truly independent voice". As such it was noted that the independence of those engaged in the monitoring, review and intervention is of paramount importance, albeit psychiatrists, legal experts or peer support.

> *Yeah, I think I think they should have, yeah, there should be advocates for people and probably peer supporter, more or less more than, but also lawyers, you know, people who know the law, that's useful too, some other completely separate from the people providing the mental health support, that has to be separate. Otherwise, it's true, the second opinion of another psychiatrist, even if they're in a different DHB, you know, they're gonna protect each other. And they might not even consider it to protect each other, they might just consider that it's, you know, the professional, you know, they feel the same way. I don't know. But they need real, real help real, real advocates. And so I think that's really important. (Lived experience)*

We heard from those with lived experience that reviewing the needs and wishes of the individual should shift from a reliance on clinical expertise to include others who can provide a holistic understanding, beyond western medicine, and support the individual to communicate their experiences, needs and wishes. We heard that there is a need to make such processes culturally safe and to ensure a range of diverse perspectives are represented in the review. Participants suggested that such review bodies should include clinicians, legal experts, mana whenua, significant others, lived experience peer advocates, and disability advocates.

> *There's very few places around the country that have peer advocates available. Where they do they can be a really helpful person to stand alongside the person who's under the Act. When that person might not have no one else in their corner. So I think setting up a truly independent monitoring body that's got a really good representation from lived experience as well was from family and whānau with this beautiful mana enhancing lens, coming from a te ao Māori perspective right from the beginning, I think it would be really helpful. It would be a wish list. (Lived experience)*
>
> *I guess I'm still quite focused on how do we work to stop people's rights not being upheld. With that idea of you know, part of it is whatever the process looks like, if there is going to be some kind of compulsory treatment and process to establish whether compulsory treatment has to be justified. That there is support beyond the support that exists. You know, as [name removed] mentioned that questionable quality around lawyers. And, the fact that there isn't any kind of independent systemic thing, that we thought, okay, let's stick a lawyer in there and that will kind of uphold human rights. I really don't think that is the answer, like that person navigate a legal system, but they have no particular skills or training or understanding necessarily of understanding mental distress or understanding lived experience perspectives. So all of these other things that I think are much more important, like, I'm not saying completely do away with lawyers, but there are actually more appropriate persons to navigate any kind of official process, whatever. Because I don't think the current process is good. But there's a more appropriate person would be an appropriately peer trained, independent person, not just for tāngata whaiora but for whānau as well. (Lived experience, Māori)*
>
> *So yeah, lived experience, perspective, Māori perspective on a monitoring body needs to be where it starts from. This will have to be monitored. If it isn't dragged back into the it will have to be monitored really, really rigorously for some time afterwards. (Lived experience)*

We also heard that the independent review body would be empowered under mental health legislation to hold organisations and staff accountable for human rights infractions, and that an independent body should have two functions.

Firstly, it was stated that mental health legislation needs to include provision for the independent reporting and monitoring of infractions of an individual's rights. It was strongly suggested that an investigation needs to occur immediately or as close as possible to report being received and that an intervention should occur when an individual's rights have been infringed upon.

> *Protections need to be embedded into the Act. Yeah. Because you're always going to get abuse of people. And, you know, there'll be always good people, and they'll always be abusive people. And it's like, people need to have the protection to be able to quickly deal with things when the abuse of bullying people is there. (Lived experience, disabled person)*
>
> *And actual action that comes out of it. Concern is that it can be monitored but there needs to be accountability for what is being found out. (Lived experience)*

Secondly, it was noted that an independent review body should exist to review of compulsory decisions, complaints, treatment orders, appeals against being under the Act or extension of an order.

We heard that such independent review bodies should replace the current role of the court and the creation of an independent review body should be reflected in the new mental health legislation.

Monitoring negative human rights indices

Participants stressed the need to for an independent body to monitor negative human rights indices associated with an individual's treatment. We heard there is a need to monitor such indicators as:

- use and length of time an individual is placed in seclusion or solitary confinement;
- use and length of time an individual is mechanically or physically restrained;
- suicidality amongst those awaiting care and those receiving care;
- number of people waiting for an appointment with a mental health professional; and,
- waiting lists for those attempting to access care.

> *But the other thing is to monitor the whole system, like, how often are you doing restraints? How often are you using solitary confinement and for how long and they have to keep track of it, and it should be a national database, by hospital or DHB. They're not DHB second database anymore, and they have to be, you know, by Māori, race, sex and all the statistics, you need to see whether that's actually working, you know…What really annoyed me when we were trying to get this movie made about a documentary about [name removed], everybody said, Oh, we don't use restraints, we don't use mechanical restraints ever. And then we said, well, where's the, you know, where's the evidence, and they never had it. There was this, this database about solitary confinement that was used, and it's there, you can get it KPI indices, and things. But physical, you know, restraints, mechanical restraints are not in there. And I had to ask every DHB, that they have it, they're required to keep records of it, I had to get into Official Information Act requests of every DHB to find out what they were*

> *doing. And, and it turned out the number of physical restraints was increasing over the years, not decreasing, as everybody had said. And actually, neither was the solitary confinement. So they need to be monitored, and not just monitored, … if it goes up, it has to be understanding it tried to get it to go down. And you know, not just that, but suicide since and not just suicides in general, but suicide to people who tried to get treatment, people who did get treatment and left, you know, it's all these things. They're all necessary for following whether the mental health status working and how, how many, what's the waiting list, how many people tried to get an appointment and couldn't even get on the waiting list? Those kinds of things that all needs to be kept track of and monitored. (Lived experience)*

Follow up/debriefing processes

We also heard that legislation should require organisations to engage in follow up/debriefing processes with tāngata whaiora who have experienced restrictive practices. The spirit underlying this process would be to assist tāngata whaiora to address possible trauma arising from enlisting restrictive practices and to develop a strategy to avoid enlisting such practices in the future. Whānau

> *And so that restorative process feels quite important to Yeah, yeah. And like, yeah, like a debrief with the patient, you know, you know, maybe that would be an opportunity to update advanced directors sort of thing to sit around and have a group chat about, you know, we didn't want to put you in seclusion, but we had to do it because of x, y and z, what could we do in the future to make sure that this situation didn't occur? Is there anything else we can add your advance directives, you know, you know, what triggered it off? Like what led to that event? You know, I don't know if those things are currently happening. (Lived experience)*

Police

Caution was raised about the role of police in responding to those in a mental health crisis. This was especially raised in relation to placing someone who is unwell in police custody. We heard that this is so traumatic that legislation should explicitly state that this is not permitted.

> *And also one thing, which is you know, I also hope that the government change the approach when it takes people to, let's say there will still be inpatient unit for whatever reason, instead of using police, they can actually use ambulances and take people to the Emergency Department instead of a police cell. I know that's very traumatic for a lot of people when they, especially Asians, you know, like for Asian, the police hold very high authority in our own country. So the police is not like here, you know, like police basically can pretty much decide - you alive or dead, in most of the Asian country. So it has a very different connotation of the friendliness of policing. Yeah, so that can be very scary. I mean, (Lived experience, Asian)*

APPENDIX 2: FAMILY, WHĀNAU, AND SIGNIFICANT OTHERS

CONTEXT

We heard from family and whānau that mental health legislation needs to be made more relevant, empowering and providing the individual with protections under a human rights framework.

> *My personal thinking right off the get go is that the Act is often used in a really punitive sense, which is really unhelpful for the person receiving or coerced into service, but it's really can be really unhelpful for the whānau around them. (Family and whānau)*
>
> *It just needs to look softer and gentler and more inclusive and more culturally appropriate right from the get go. (Family and whānau)*
>
> *I feel like it's a very blunt instrument, and his case, treatment under the Mental Health Act as compulsory medication. And that blunt instrument is pretty much where we're at because of where we live in the country, we have very limited access to support services. (Family and whānau)*
>
> *This is a really difficult space. And I don't think that others should be pushed into particular actions. I don't think that that there's best practice and health to get around coercion. Everybody whaiora whānau, whoever they choose, must have opportunity in education or to actually create informed decisions. So that looks like time and energy and sharing access options and treatment options in a holistic way, in a culturally relevant way. (Family and whānau)*

We heard many accounts from family and whānau of loved ones having been traumatised as a result of having been placed under the Act. We also heard of loved ones who had died as a result of how the mental health system treated the individual.

> *From a personal point of view, and I wish to add, my son was only one year in mental health services, and he died because of how the system treated him. (Family and whānau)*

We heard that many family and whānau believe that the Mental Health Act has effectively protected clinicians. Rather, from family and whānau we heard that mental health legislation should aim to protect the tāngata whaiora.

> *So I wonder if I reflect and think, are we writing legislation for whom, and I think that we really need to be clear on the fact that this legislation needs to protect whaiora, it needs to protect whānau. because currently, as mentioned, it protects clinicians who are, which is understandable, very fearful of the repercussions of poor practice. So moving forward, I think we need to define what poor practice looks like. And poor practice looks like not pulling other people into the fold. That may be a parent that may be a friend, that may be a colleague. So I think that we bring those people in, right at*

> *the get go. But always, always in crisis, because crisis, unfortunately, well, it offers us an opportunity, you know, to reshape things. (Family and whānau)*
>
> *We need to think about the positives that whānau can bring to wellness. We are nothing but connection, and we are unwell without connection. So if we were going to write legislation, it would be to ensure a system to enable connection, not protect clinicians. (Family and whānau)*

We also heard that definitions of family and whānau should include young people and children. Such inclusion acknowledges that young people and children, and not exclusively adults, can provide support, and that often they are already playing this role in families.

> *We need to ….and I also want to acknowledge the differences I sit here with my experience as a child. We also have to keep in our heads that there are young people that need the system to acknowledge that we too, need support. (Family and whānau)*
>
> *I would like to just acknowledge the young people, and I only speak from my own experience of like, opening the door for the night nurse to come and give my mom medication or something and never ask us sort of how things were going down at home even though we were kind of the experts on the situation. And in for, you know, young people's wisdoms to be acknowledged and to be heard is really important, but also to have some other kind of features of the mental health system that will hold and not in a punitive you're a bad parent, kind of I'll take your kids away from you way but just to awhi now to make sure they have the right free sources. Make sure there's enough kai in the fridge. You know, all of that stuff supports whaiora who have parental responsibilities, you know? Yeah. And just just making sure that there's wraparound supports when parents are put into awards and stuff like this. Not punitive, but just making sure that there's other people involved that can hold the whole family. (Family and whānau)*

We heard a great deal of anger and frustration from family and whānau about the Mental Health Act, the mental health system, and the failure of the system to recognise the importance of family and whānau as a central component of the distressed individual’s wellbeing.

> *It's kind of it's not a one size fits all but it's about really that reformative culture change around we are the people that stand with the whaiora regardless of the professional so we are the most you know we are integral to wellness. (Family and whānau)*

We also heard that families and whānau often feel as though clinicians blame families for the individual’s mental health challenges. We heard that fear of being seen as problematic acted as a barrier to family whānau from advocating for themselves.

> *The system believes that we are the cause of the problem. (Family and whānau)*

SYSTEM AND SERVICE FRAMEWORK

From family and whānau, a number of recommendations were made to changes in the mental health system that would significantly reduce rates of compulsion.

We heard mental health legislation should be accompanied with workforce development, monitoring and accountability.

> *So sometimes we can put things in legislation, but it's actually practices and we know that and in some services, they are very much we can clearly impact partnership with family. And sometimes it might be individual clinicians, but another so it's about how do we make sure any legislation comes with workforce training, practices that enhance that happen and really do happen? And sometimes some kind of accountability or responsibility may sometimes make that happen? (Family and whānau)*

We heard that family, whānau and significant others need assistance to enable them to support tāngata whaiora. We heard that such support is essential to reducing incidents of compulsory treatment, as families adequately trained and supported can address issues as they arise. In this context, assistance given to family and whānau prevents escalation to an acute level.

> *If a family is not taught how to take care of the person, and they're gonna have to call the police, they don't know how to do it, , they just, you know, family can get out of control as well, you know, and because they don't know how to deal with this person that they've not been trained, or taught how to deal with a psychotic episode. People need to learn how to deescalate situations and try to get help get the other person under control. (Family and whānau)*

> *I'm interested in that, from a from a rural perspective, which is my work and my lived experience, is that where there's limitations in terms of the resources that are available to support the patient, often the family becomes the only support mechanism. And I think that's something that has to be balanced very carefully. Because trying to care for someone when you're not a clinician, when you're not a probation officer, a counsellor, a drug and alcohol clinician, is really difficult when you have limited access to resources. (Family and whānau)*

> *I think the legislation should include the need for support, for financial support that basically, there's not enough financial support right now as it is. I mean, that's one of the big problems we have actually, the people have tried to get help, and they can't, they're put in waiting lists that this eating disorders is terrible and ballooned, hugely, there's there must be huge lines, for people to get into the eating disorders, treatment facilities. And they you know, they just get fobbed off, if they, you know, even if they're suicidal, they might not be able to get treatment. (Family and whānau)*

> *So, somehow, legislation has to have say that the government has to support the mental health, and the family and you know, the whole thing, it's not just about*

> *treatment, and whether they can, if they have the money, use it, they just need to do it. (Family and whānau)*

> *I think it's all well and good to put this into legislation. And I know we're not talking about, you know, budget issues here. But I think one of the biggest challenges we face in our rural communities is that we don't have the resources to be able to deliver the support people need. So that needs to be looked at within the bigger picture. Like I said, Well, I'm good to have it in the legislation, but if it can't be delivered, you end up with a really difficult, traumatic situation for the person receiving here and for the people caring for that person. (Family and whānau)*

We heard from family and whānau that people, in general, should be encouraged to develop advance directives.

> *Advance directives aren't usually developed until someone's already had an experience of unwellness. I mean, wouldn't it be great to turn it around, and just like we encourage people to have a well written, you know, just if it became the norm for people to consider what they want, when they might be in a position not to make good decisions, you know, for themselves. So, you know, like, I'm quite big on wellness plans, and just in future intentions, that kind of thing. And we have to do that, you know, with older members and our family or people living with ongoing illness and so on. So just, I'm having those conversations early, and it will be great to socialize that. (Family and whānau)*

We heard from family and whānau that acute inpatient environments can exacerbate someone's distress. We heard that mental health legislation should require inpatient settings to be designed to reflect therapeutic and supportive environments.

SHOULD THERE BY COMPULSION?

From family and whānau we heard often competing perspectives about whether mental health legislation should include provision for compulsion.

Those supporting the removal of compulsion

Family and whānau who supported the removal of compulsion from mental health legislation referenced the incompatibility of compulsory treatment and the individual's human rights. We heard that compulsion is counter to human rights and results in retraumatising people who are already in distress.

> *I just can't make that point strongly enough, thinking about how traumatic the whole process can be. And it doesn't have to be that way. (Family and whānau)*

> *A real failure of care of our public health system is that it adds distress rather than relieving distress. It's really important that any legislation actually minimizes that damage. (Family and whānau)*

> *I think that the words compulsory treatment are just so incongruous, I don't think you can successfully force treatment. (Family and whānau)*

> *That'd be great if we didn't have to force people to have treatment, because that didn't do any favours either. You know, that was not good for her. It wasn't good for anyone. However, that early intervention wasn't available. (Family and whānau)*

> *I just, yeah, I just find it really wrong, that people seeking help for protection in safety for the loved ones and for themselves and for other people can end up undergoing an experience that is traumatizing in and of itself, and compounds, the whole, you know, original illness and distress. (Family and whānau)*

> *Mental health services under estimate the traumatic impact of compulsory treatment. (Family and whānau)*

Family and whānau shared their guilt and regret of having endorsed decisions to place their loved ones under the Mental Health Act. We heard that they had provided their endorsement because of fear and privileging the knowledge of mental health professionals.

> *So I'm kind of, but I'm well aware of the family and whānau that are so fearful for the life and the safety of the loved one when they're unwell. They end up going down that that pathway out of fear. (Family and whānau)*

> *But I know that people are really scared of life without that option for compulsory treatment, too. So I think the way forward needs to strike a really careful balance, you know, building things up. So it can be used less and less often. (Family and whānau)*

Family and whānau participants stressed that no compulsion requires a shift in the way we view mental illness. We heard that a reliance on dominant western biomedical psychiatric models has resulted in a singular privileging of psychiatry. Rather, we heard that there is a need to focus on models of early intervention and holistic support. We heard that this would require "New Zealand to have a lot more community-based, earlier intervention and support". We heard that support should include the appropriate implementation and widespread use of advance directives and adequate resourcing for mental health support. We heard there is a need to shift mental health legislation from a singular crisis intervention focus to prevention and early intervention. We also heard that this would require a financial commitment from the government and that new legislation should provide this direction.

> *So when we talk about having no compulsory treatment, or there's this real sort of underlying fear here of people are going to get hurt without that. However, I really strongly agree with around that early intervention, because I think both times could have been avoided had services been engaged earlier on. So I know that the second time that my mom became unwell, she went back to her mental health team. From the like, she saw the early warning signs that she had bipolar disorder type one, so she knew that the racing thoughts were coming along, she wasn't sleeping well. She had a significant trauma and so she tried to get help. However, they it was made really, really*

> *difficult for her. So there was there was a bunch of processes that she needed to go through to try and reengage in the services and in the end, it was just it was too little, too late. I find that even in my own experience with mental health as well. I suffered depression, probably all my life but diagnosed 10 years ago. And as a result of my mother's suicide, I developed PTSD, as I found here. To get help, for that, I had to wait a year on the high priority list, to be able to start getting trauma counseling funded I was okay. (Family and whānau)*
>
> *I think the biggest problem is getting early assistance. And I think this is where there aren't enough conditions available, or enough people to look at the situation to actually talk to the person who needs the assistance. (Family and whānau)*
>
> *Ideally, we wouldn't have a system that requires that gets to such a crisis point. We need to look at things differently right from the get go. (Family and whānau)*
>
> *We need New Zealand to have a lot more community-based, earlier intervention and support. And, and I would hope, if we are able to grow our communities in that way that we could avoid compulsory treatment… So, I guess for me, that's, that's a simple, big picture answer. You know, I think we actually need to do things differently. So we don't end up having to utilize the Act. (Family and whānau)*
>
> *I think, you know, when people need help, and support that it needs to be given to them in a timely way, in the right place, as well. (Family and whānau)*
>
> *They have, they pick up the early warning signs, and they and then they see this deteriorating behaviour, and it may be a family or maybe a neighbour even. And they feel really frustrated because they contact services, may be even the crisis team. And they told, you know, unless the person has seemed to be risking their own lives, or that someone else, but they can't do anything, their hands are tied. (Family and whānau)*

From family and whānau we heard that the provision of comprehensive mental health care, adequate resourcing and holistic support would mean compulsion would become a rarely required alternative.

Those rejecting the removal of in compulsion

Other family and whānau told us that their loved one was a significant risk to themselves and compulsory treatment was a necessary intervention. There was a real sense of fear from some whānau that removing the compulsory treatment would put their loved one at greater risk. This was especially noted in situations where the individual did not acknowledge that they were unwell or in need of treatment. These family and whānau greatly appreciated the provision of compulsory treatment.

> *Yeah, I tend to lean more towards compulsion where it's appropriate. There are some people who are being treated who don't necessarily have the capacity to make that decision for themselves. The young man of my life doesn't believe he has an issue,*

> *and that he has everything under control. And it has led to a number of psychotic episodes, which is why he's currently under the Act. (Family and whānau)*
>
> *When my son first became unwell, he could not get any help. We were constantly being told that it was just bad behavior or he needs to change his diet or when he was to pass clearly unwell, irrational, delusional, etc, and needed help. And in that case, he admitted himself to hospital age at just 17. He wasn't quite 18, he phoned the police up, and he said, I feel I'm gonna do something, whatever. And we were out of the house that day and he got himself, he got himself into hospital. I think the thing is that he's been under the Mental Health Act, and under community treatment order ever since. And one of the things is because he doesn't believe he needs treatment. And if it wasn't for the Act, he wouldn't be receiving any, because he would just disappear. I think one of the things has been amazing is that he really nowadays is in what I would call recovery, he is a completely different person, he is living in supported accommodation, he is managing in that. And I would never believe that from 13 years ago, that that won't be possible. And so he went all the time he you know, was doesn't want to be in the act. But then I also know that wouldn't we're not for the act, he would refuse treatment because he says I don't actually need whatever. (Family and whānau)*

We also heard that mental health legislation should specify diagnoses in which compulsory treatment is permissible. An example includes eating disorders, whereby the individual is at risk of death without medical intervention.

> *From perspective of eating disorders, compulsory treatment, there is definitely a need to have within legislation. So from our perspective, across general mental health, it really depends upon the diagnosis and the illness. So it's, in some illnesses, it is a defining point, for example, within anorexia nervosa, that this is one of the classic traits that somebody is unable to make decisions and doesn't have the capacity to make decisions regarding life, saving, threatened saving treatment. So it really depends upon the diagnosis and who's involved in making the diagnosis. We have many, many members that have loved ones that are literally only alive today, because they were under compulsory treatment orders. So I think to completely remove that component would be short sighted. In that respect, it really, really depends on diagnosis, clinical diagnosis. (Family and whānau)*

IF THERE IS SOME COMPULSION WHAT WOULD IT LOOK LIKE?

We heard from family and whānau that mental health legislation needs to adhere to a human rights framework and international conventions, such as the Convention on the Rights of Persons with a Disability. Within this context, we heard that new mental health legislation should position the individual's rights to decision-making within a context of their wider social support structure, albeit whakapapa or metaphorical whānau.

> *And what that also looks like as having a more open understanding of what whānau because oftentimes when we're working in this space, we think oh, now there's no there's no whānau that we can pull in. But whānau are who your people are now so we just need to dig deeper ways. (Family and whānau)*

> *Next of kin is not necessarily the best definition of who should be involved. It really has to be, you know, like flat mates. We've lived with someone for a long time. And support worker who's been engaged with that person for, you know, five years, 10 years, you know, a family friend who's known the person for a long time, and can clearly say, actually, this person does have a relationship with their parent, which isn't going to be helpful right now, for the step of the recovery. So it's like, who can solicit all that information and pull it together and make some decisions? Because at the moment, it's really ad hoc that people get left out when they shouldn't be? (Family and whānau)*

Family and whānau who support some compulsion described that compulsion needs to exist in parallel with a number of safeguards and accountability mechanisms.

We heard that there needs to be better “safety nets” surrounding diagnosis and the use of compulsory treatment orders. We heard that provision needs to be made for independent second opinions, timely investigations of complaints or issues as they arise, that clinicians’ need to evidence their prescribed treatment is in adherence to best practice. We heard that treatment should be independently reviewed to ensure it adheres to best practice. Finally, we heard that family and whānau should be given the right to “audit” services.

> *However, there does need to be a better safety net, because what we're finding is there's a lack of accountability in some of the diagnosis and the use of compulsory treatment orders. (Family and whānau)*

> *A safety net is absolutely needed. And when there is the facility to allow for Second Opinion that must be brought in. And it must be brought in from an independent source, as opposed to the pool of the treating clinicians to whom they're connected. We have a very small pool of specialists, clinicians within New Zealand, for example, specifically with an eating disorders. So to bring in somebody to do a second opinion or assessment, to support a colleague is highly inappropriate. (Family and whānau)*

> *There do need to be safety, safety nets in place, and accountability, and a quick investigation when there is an issue, and not the complex and lengthy ones that are family and whānau are experiencing in an emergency situation. (Family and whānau)*

> *All treatment that is applied under a compulsory treatment order must be to evidence best practice treatment, and that must be a no brainer. And that's not happening currently. We are having loved ones and children who are being treated under the compulsory treatment orders. And treatment is not adhering to recognized evidence treatment models. That's not okay. (Family and whānau)*

> *I think we need I think we need to have whānau doing audits. Yeah, I think that's really important. If we embed that into legislation, we should be auditing services. (Family and whānau)*

TE TIRITI O WAITANGI

Family and whānau participants emphasised the importance of embedding articles of Te Tiriti in new mental health legislation.

> *About the Treaty of Waitangi… the legislation is developed by non-Māori for Māori and it asks us to endorse Māori being placed under compulsory treatment Act. With the embedding of Te Tiriti o Waitangi into the legislation it acknowledges that Te Tiriti is a constitutional authority upon which all parties are mandated, it shifts from a compulsory treatment to a value based approach that is individualized as well as collective with whānau involved. And that includes is defined by finite focuses on relational and holistic practice across the sector, and increases the accountability to tāngata whenua systems. (Family and whānau)*

> *I think just we need to embed the core principles of the Treaty in this legislation. And when I think about that, that means being clear about what principles are, what values are. The current legislation, I don't think pays enough attention to what things like respect means, in practice, about partnership, participation and protection are the three core things of Te Tiriti o Waitangi I want to see embedded in this legislation, and when we think about what those words mean. So you know, partnership. So equal and form decision-making, participation, giving whānau the opportunity at every point to contribute. They know their person best. And in protection, yes, we need to ensure safety, not only of the unwell person in the whānau, or caregivers, or flat mates, or whoever they're living with, or the community and the clinicians, you know, involved in treatment, but we need to balance it with protecting that person's human rights and ensuring their dignity and avoiding further harm. (Family and whānau)*

We further heard that Te Tiriti needs to be embedded into guidelines arising from mental health legislation.

> *The articles of the Treaty of Waitangi need to be embedded into the guideline and highlight partnership and shared learning and shared decision. The workforce that's delivering the Act needs to have really strong training, and be exposed to, and understand, whānau and lived experience journeys, as well as Te Tiriti o Waitangi. (Family and whānau)*

We also heard that adherence to a principle of equity acknowledges that the Act, in relation to Māori, needs to be appropriately resourced.

> *Equity and co-design needs to be key function within the legislation, tino rangatiratanga and mana motuhake supports Māori in a meaningful way it needs to be resourced and invested. (Family and whānau)*

Family and whānau asserted that Te Tiriti should be reflected in the development of Māori-centred legislation, with the understanding that the principles embedded within the legislation would equally benefit non-Māori. We heard support for this approach on the basis that Māori will continue to experience inequities if legislation adopts a simplistic approach of attempting "to put a Māori lens across" legislation.

> *I feel it's really, really simple. If we get it right from Māori, we do get it right for everybody, particularly from a whānau perspective, because it pulls our people in. And it also flips the script in terms of looking at the individual and looking at the world in which they exist. And that will cover understandings of what stress looks like and where it comes from the whakapapa of that, in terms of understanding the impacts of colonialism, and picked it understanding the effects of exclusion from housing and education and employment, and the ongoing and quite lasting impacts of those. Yes, so really, we need to walk the talk and that and that space and honor Te Tiriti and use Māori models. I think that Te Whare Tapa Wha, although it has awesome has been kind of thrashed, and trainings. And people don't necessarily take them or embed them within their practice. So I recommend that we use bringing Rose Pere's model Te Wheke. I think that that's more wholesome in terms of understanding the waters that we move within. (Family and whānau)*

> *It's I think one of the things too, that we, if this if the cultural education is wider spread, it'll make people much more aware of their other cultures, the problems that migrants refugees, you know, sort of complete ignorance all around that people are living in the country with different values. And if it's not addressed, this kind of perpetuates itself. And also, there's a problem we have with so many clinicians being trained elsewhere with different cultural backgrounds, languages, etc. clinicians, nurses, everybody, you know, it's a polyglot. (Family and whānau)*

Many with lived experience shared possessing a lack of confidence surrounding Te Tiriti and its application to mental health legislation. Rather than referring to Te Tiriti principles or articles, this cohort referred to the importance of key aspects of te ao Māori being reflected in mental health legislation.

Te Ao Māori Tenet	Description	Quote
Tino rangatiratanga	The impact of colonisation has negatively impacted on the tino rangatiratanga of whānau and created barriers to whānau engagement with health and help seeking. Adherence to the Treaty would be reflected in the provision of peer support navigators who could walk alongside tāngata whaiora and the whānau to offer protection and keep them in a place of tino rangatiratanga	*The internalized racism and biases often adds to the stigma for people asking for help, and how many Māori possibly don't want to engage with service just because of how they've been treated previously. Māori have had a higher percentage of being placed under the Mental Health Act then compared to Pakeha. And so we do we need to look at that and how does that the trauma that inflicts on the person and their whānau. and again, I'm thinking about Māori navigators, peer support navigators in order to make that facilitate that process. So there's not more trauma is inflicted on the person. (Family and whānau)*
Whānau	Whānau was described as a central tenet of te ao Māori. Importantly, for non-Māori, family was equally regarded as essential. Family and whānau stressed one of the important aspects of whānau rests in the strength of collective decision-making. Adherence to the tenet of whānau ensures whānau are included in decision-making, treatment and support of tāngata whaiora.	*From Te Manawa Taki's perspective, and this is agreed by both our family in the experience, leadership group and telling them family is the smallest unit of measure. And so because whānau are the smallest but central part, they have to be involved, right from the beginning, through to discharge or whatever. And what we neglect to do is involved whānau voice in any journey that our loved one goes through. So from a Te Ao Māori perspective, whānau don't see the person with experience as separate, they see them as part of their whānau. And it might not be like I said before blood relatives, it might be significant others, but they voices are equally important. (Family and whānau)*

Mātauranga Māori	Provision for the treatment of tāngata whaiora should include the possibility of engaging in te ao Māori practices. Such provisions include: ▪ te ao Māori healing practices (that may occur outside of a western clinical setting) ▪ ensuring clinical environments include provision for kaumātua and tohunga.	*And if we had, you know, kaimanaaki and matakite in the community, working alongside whānau, right, bright, early intervention, the likelihood of that outcome occurring would be significantly reduced. (Family and whānau)*
Protection	We heard concern about the lack of cultural awareness amongst those who work in the mental health sector. Reference was made to the principal of protection to underscore the requirement that health and mental health staff are appropriately trained to acknowledge different cultural values and confronting, and working through, racism that can affect clinical and supportive practice.	*I think the thing is, as recent New Zealand I really believe that. It's key to this is education and education of clinicians, staff, etc. because I don't believe that many of the staff have any idea of what of cultural values etc. And under the necessity for this, and I've seen it many times, I've seen staff in the hospitals clueless, and it's horrifying. And it should be compulsory that they actually go through training in what is culturally appropriate, etc (Family and whānau)*

CAPACITY AND DECISON-MAKING

Introduction of a test of capacity

From family and whānau we heard competing viewpoints surrounding the introduction of a test of capacity.

Those in favour of a test of capacity stressed the absence of a test indicates coercive healthcare practice. In this context, coercion needs to be appreciated as an infringement of the rights of tāngata whaiora.

> *And around the capacity thing. I'm always apprehensive I'm apprehensive about this legislation, just full stop, but I think that potentially using that universal approach to understanding capacities potentially a good idea because from my perspective, the people who have been dear to me who I've lost under the Act would have flown through capacity assessment so currently, that sits with the clinician, sometimes informed by parental wisdoms or not, and I don't think that's helpful. So all choices need to be made by the whaiora Yeah, otherwise we are doing coercive healthcare and that's not best practice. (Family and whānau)*

Those with contrasting views related that a test of capacity would place whaiora at risk. We heard that such risk can be understood in light of family and whānau belief that their loved ones would have demonstrated capacity while in a severely unwell state.

> *I've got quite strong thoughts around this, because when I looked at the questions, or the decision-making capacity, I can say hands down that my mum would have passed every single one. And she was so unwell, she was not capable of making her own decisions. So by the criteria, it would be defined that that she could, and it was something I had a lot of challenges with when she was in the hospital was around her decision-making capacity. And so although she was placed under the compulsory treatment order, and didn't have decisions about which treatment she would receive, she was still deemed by law to be able to make decisions in regards to things like finances and property. So she was attempting to purchase multiple properties throughout the country, a farm and a caravan park, and yet she didn't have the money to do that she did have some money, but not the money to serve as long mortgages or even the capacity within yourself to be able to manage a farm down the other end of the country. And there was absolutely nothing I could do even with enduring power of attorney because it did not come into effect. She wasn't deemed mentally incapacitated. So yes, something I really struggle with because by criteria, she was she had capacity for decision-making. But as someone who knew her and who knew her when she was well, she was absolutely not in the right frame of mind. But she could*

> *articulate I think, very well. Very convincing to someone who didn't know her. So I can't stress enough how important it is to involve family we never got involved in her treatment when she was placed under the compulsory treatment order was only the doctors. So it didn't matter whether she refused, or consented or whether I refused or consented it was just whatever the doctor thought was the appropriate medication for her. And it just flipped from a totally manic stage to a zombie consultation process. (Family and whānau)*

We heard the tension between the two family and whānau positions would be alleviated if mental health legislation ensures that significant others' perspectives are included in capacity assessments. In this sense, we heard that it is important that mental health legislation moves away from privileging clinical assessments to a more holistic assessment. We heard that such capacity-related assessments should include multiple viewpoints that might include clinicians, significant others, whānau worker and kaimahi.

> *So I'm thinking around that was one of the questions within the document is who can make these assessments and who's involved in the assessment? So what I'm hearing is, is that family need to be involved in any assessment, and maybe looking at who's doing the assessment might be an important part of the picture that might not be fit family doing that? It's no, I'm saying, but it's around who's involved in it, what that process looks like. (Family and whānau)*

> *In terms of capacity, who says that clinicians are the only ones that can actually assess capacity? We are really clear at Te Manawa Taki that the whānau worker that's walking alongside the whānau, as well as the support person or kaimahi that are walking alongside the lived experience, should be involved in capacity making decisions and supporting the whānau to understand what that means and relative to the loved ones during supported decision-making. (Family and whānau)*

> *Yeah, so another thing that's missing, and the sort of definition of capacity is change in state and behavior. So I talked before about getting the full picture. But often what happens with the clinical view is they only look at the current presentation, and there's not enough consideration given for that individual. Is this normal for that person, and I know the word abnormal is used. But, you know, we all have different abilities and different levels of functioning. And you know, for some person who doesn't really deal with property all the time, that's perfectly normal for them to want to continue to do that. But you know, for another person who's only ever bought one place in their life, then that's actually a significant aberrant change in state and behavior. And, you know, for someone like, you know, thinking of my sister with bipolar, you know, there are many clues to her moving into a manic state, but they're not the same for other people living with the same disorder. So it's really getting that intimate individual picture, you know,*

> *looking for those clues, like increased spending habits, but for some people it might just be sleeping this or, or doing more painting or it might be just engaging in more risk taking behavior. You know, there's a lot of variability. And I don't think the current Act and guidelines give scope to the full range of individual human uniqueness and family uniqueness in terms of, you know, someone user would have said before how much they hated dysfunction, like, who decides, you know, a family is dysfunctional, like every family does family life differently? And it's not for an outsider to say if it's normal or not. So how can we somehow incorporate that into into better legislation? Recognizing individual uniqueness? (Family and whānau)*

SUPPORTED DECISION-MAKING

We heard from family and whānau that clinicians are under resourced. As a consequence we heard that many family and whānau feel that decisions pertaining to their loved one had been "bulldozed".

> *Clinicians, they just got like this bulldozer approach of doing things, possibly because they are stressed, possibly, they're short staffed, it's a tough issue, but they just bulldoze the way through things like applying the Mental Health Act. And I think if they were to involve the person and the whānau around the person in that process, but also to take collaborative notes from everybody, because we all have different perspectives. I mean, you will possibly all know, once you get your medical file, what is written on the medical file does not always reflect accurately what happened. And so I think if we could maybe have a collaborative note writing in this process, it will be more transparent, and, and possibly offer a bit more accountability. And finally, I wouldn't want to just agree with what Eileen said, a little bit about, you know, more, some people need more support while making decisions and offering more alternatives. (Family and whānau)*

We heard agreement for supported decision-making from many family, whānau and significant others. We heard that this was based on the capacity of tāngata whaiora to make decisions for themselves.

> *I think supported decision-making, when it's clear that someone has that capacity to do it themselves. (Family and whānau)*

We heard a great deal of support for legislation to require family, whānau and significant others to be part of supported decision-making.

> *In terms of supported decision-making I don't believe this is just the psychiatrist's role. I think it's should involve whānau, we all think whānau are first point of contact right throughout the journey, being involved in supported decision-making at every step, by*

> *the use of wananga, whānau family who think that, you know, our services currently don't invest the time because they think it's time consuming. But what we're saying is that, if all the early intervention strategies have not worked, then we have to take whānau on the journey, and make it work. So regardless of the time taken, we believe quite strongly that you can't have the equity without co- design and co-design without equity. And that's exactly what whānau, regardless what culture, they just want to be helpful. (Family and whānau)*

Notably, we heard a degree of reluctance from some family and whānau members for supported decision-making because, in their experience, their loved ones had previously chosen to exclude them from decision-making.

Such exclusions posed a challenge to family and whānau who wanted to be involved in their loved ones' recovery journeys. While family and whānau agreed that families should be excluded in cases of historical trauma this cohort asserted the rights of family and whānau to be involved. Such involvement poses a challenge as it can negate the wishes of the tāngata whaiora and places an expectation of tāngata whaiora to evidence their decision to exclude.

> *I think family should be the first, the first. The first idea should be to include all the family and the service users themselves and, you know, family conferences, in terms of the treatment, obviously, sometimes, you know, not every meeting has to be with the whole family and everybody together. But the final decisions about treatment and things I think should include them. Except if the family is the problem. That's what some people say, well, but the family can be the problem. And in some cases, they are you know, if they've got an abusive family, maybe that's why they're having trouble, they had abuse as a child. So there, there have to be some kind of safety nets for that. So if safeguards, but I think the default ought to be that people should all be trying to be included when important decisions are made about treatment. (Family and whānau)*

Family, whānau and significant others are essential

We heard that family and whānau are an essential component of supported decision-making. We heard that assessment, service provision and discharge plans need to view tāngata whaiora holistically. We heard that this means that tāngata whaiora need to be regarded as part of a supportive network of family and whānau. We heard that such a holistic focus means that a collective notion of self needs to be included in mental health legislation. We also heard that the inclusion of family, whānau or significant others in decision-making needs to be explicitly included in new mental health legislation.

> *I think that the family should be helped to be involved, they can be part of this support group to help them make decisions. (Family and whānau)*

> *From more my point of view, I think that family whānau are included in the treatment plan. Right from the beginning, and that this is actually made as part of the thing. So not just, oh, well, we'll inform families, but they included in the planning and the discussion about planning right from the start. (Family and whānau)*

> *Oh, yeah, we need to be involved from the get go that needs to be guided by whaiora. And goes back to you know, who the people are to bring in, that might not be mom, it might not be dad. But it could be somebody. And I think we're failing when we work on the ground, and we're not pulling people in. So I think that there needs to be levels of accountability there. So it is embedded in legislation. But until we kind of rewrite or flip the script of those biomedical understandings of what distress is, then people will continue to operate in a really individualistic way. So there's a couple of things challenging the models that they originally are currently working with to be more whānau focused, that giving professionals space to work that through because people know on the ground that we should be working with whānau, but then these tensions about how to do that. So making it actually possible with reprimand, if you don't (Family and whānau)*

> *I've never ever been asked anything when on a discharge from hospital as a family member. We've never ever been approached and said, What do you think of the treatment or anything like that we've had about in our family, at least 12, 14 hospital stays, some of them as long as nine months. (Family and whānau)*

We also heard sometimes competing perspectives on the rights of family and whānau to be involved in supporting tāngata whaiora decision-making. On one hand, some family and whānau asserted that it is their right to be involved, whether or not tāngata whaiora endorsed this involvement. From other family and whānau we heard that family, whānau and/or significant other involvement rests on the wishes of tāngata whaiora. We heard that the rights of tāngata whaiora to elect who they would like to support them should be included in mental health legislation.

> *I think it should be legislated that all mental health support would involve an elected person by the whaiora. And so if we don't hook them up with somebody that is going to stand alongside them we are failing; failing from the get go. (Family and whānau)*

> *It's about making sure that there's someone there, isn't it, though? So it's about, you know, from what I'm hearing is that we need to hear from tāngata whaiora whether that's direct family, whether their extended family, whether that's a friend, whatever. (Family and whānau)*

When family and whānau are excluded

Family and whānau shared considerable pain and frustration after having been excluded from the care and support of tāngata whaiora. We heard that families and whānau have been prevented from visiting and supporting their loved ones while in acute settings, that they have been excluded from the individual's treatment and have faced barriers gaining access to a clinician to discuss their loved one's needs, treatment and the way in which families and whānau might support their loved one. From family and whānau we heard that clinicians had invoked the Privacy Act, in accordance with the wishes of tāngata whaiora, to effectively exclude family and whānau from engaging in the individual's treatment or in-person support.

> *We are having families and whānau excluded and privacy under the Mental Health Act, and it's being weaponized to exclude family and whānau. (Family and whānau)*

> *We weren't allowed to go into the lockup ward. And when we go there the whole, the whole system was one sided, we couldn't tell who was clinician and who was staff member in the lockup ward, it was hard to get somebody to talk to us, we had to call for meetings. I think if the process is handled very differently right from the start by involving family. And I understand that not all families can be involved or that they are no families. But most of the time, if you delve a little bit deeper, you will find that families do key and love the loved ones. And they just need a little bit of support to help them navigate this complicated system. (Family and whānau)*

The exclusion of family and whānau was described as a complex issue - marrying the wishes of tāngata whaiora and the needs and wishes of family and whānau.

> *I think that the person that's using the services need to have a say, but family also should have a say, because I think we are the ones at the end of the day who have to pick up the pieces. (Family and whānau)*

Some family and whānau shared dissatisfaction with having been excluded because their loved one had made a decision to exclude them from decision-making. We heard that this created a high degree of frustration, confusion and pain for family and whānau who wanted to support their loved one.

> *Family need to be involved every step of the way. And, and I can understand that my son was angry with us at that point, but that was part of his condition. And I think most consumers and families will argue that from time to time, that will happen but when the person is unwell again, you know, we had a really good relationship under normal circumstances our relationship was Very good in and clinicians need to take that into consideration, but they didn't they excluded us every step of the way. (Family and whānau)*

> *At the end of the day, we are the people that pick up the pieces. We love him and know him based. We're the first ones to notice signs of deterioration, and we are the ones that will contact the services and point it out to them. (Family and whānau)*

From other family and whānau we heard that it should be the decision of tāngata whaiora about who should be their support person(s) and who might have access to their personal information, including being permitted to discuss issues pertaining to tāngata whaiora with a clinician(s). We heard that such decisions are based on the rights of the individual as well as an acknowledgement that some families and whānau are the source of the individual's "problems" and, in these situations, it was understood that the individual's wishes regarding their engagement with family and whānau need to be supported.

In navigating the tension between the rights of tāngata whaiora and the needs of family and whānau, we heard that in situations of exclusion, provision should be made whereby clinical staff revisit the issue of engagement with family and whānau, while respecting the right of tāngata whaiora to reject such opportunities. We heard that such opportunities need to be revisited at regular intervals within a care environment.

> *I want to acknowledge that, that it's really hard sometimes for family to say, we know that maybe sometimes we're not the right person, we want to be supportive. But sometimes it might not be the right thing for this person right now, because they see us as both their family but sometimes, because we asked them to go and get treatment, we're seen as the problem initially. And so their ability to be able to see your perspective, but to continually look at how do we reconnect, if there has been some breakdown, because of your desire to look into someone 'cause sometimes someone gets angry with it. But the ability to continue looking at how do we really there were a few notes going on there just so that we record, they know that people are supportive of that concept. (Family and whānau)*

Ensuring family, whānau and significant others are best positioned to support tāngata whaiora

We heard from family and whānau need support and education in order for them to be able to support their loved one. We heard that family and whānau are often confused about their loved one's mental illness, the nature of their loved one's distress, treatment options and what it means to be placed under the Act. Within this context, we heard from whānau and family that mental health legislation needs to include provision for supportive education of family members. We also heard that such education needs to include supportive in-person encounters with mental health professionals.

> *I think, right at the start, you know, when parents find out… they are in shock when this happens to a loved one, when they're placed under the Mental Health Act; what it could*

> *look like without Mental Health Act, I think, gentle support for families informing us better. I had no understanding when the psychiatrist did call us to say that [name removed] was placed under the Mental Health Act. And when I started asking him questions, and I said, please don't medicate him for, you know? Or can we have a bit of conversation, he just said to me, "He's under the Act", that's it, "and he wants nothing to do with you". (Family and whānau)*

> *I think one of the problems too, is that family don't understand the nature of the distress that they are watching and looking at and observing as an outsider. And I can remember very clearly, my son was had been in hospital about two weeks or so. And so being also being an observation, and we were called his sister, my husband and myself were called into a family meeting and without him, and we're told the possibilities of if he had schizophrenia, what this would mean and what the symptoms were blah, blah, blah, have a whole lot of stuff, it was run off. There was no diagnosis for him for several months after that he still remained in hospital. But at no time, did anyone ever return to that original discussion. And explain further now, you know, in fact, I actually got a phone call one night from my son and requested a third opinion. And I got a phone call at nine o'clock from a psychiatrist who said, and I was alone, my husband was overseas and was told what would you say if I told you your son had schizophrenia? And I went, what? You know, again, no, no kind of explanation, etc. I was devastated. So, you know, somehow other families need to be involved, and they need to be looked at educated in a general way. But specifically, given some kind of prognosis, etc. I've just had problems, cardiac problems. And when I go and see the cardiologist, I get a whole rundown. And my husband has, these are the possibilities. This is what can happen. If we do this, blah, blah, blah, whatever. Doesn't happen in mental health. And I don't know why. It should, it would clarify an enormous amount. Okay, they might be wrong. But they can, the cardiologist might be wrong, but at the same time, this one's given possibilities. (Family and whānau)*

> *I think the support could have been a lot better could have been improved 100%. (Family and whānau)*

> *I know that when my son was first placed under the Mental Health … I don't think I was in a position to make the right decisions either simply because I wasn't educated enough in that area, and much more educated these days. So, again, yeah, I just don't know. It's a difficult one for me. (Family and whānau)*

Many family and whānau shared accounts of feeling intimidated by mental health professionals. We heard that such intimidation has created situations where families have been reluctant to question staff practices. We also heard that some family and whānau may be reluctant to assist with decision-making because of fear of reprisal: either a negative impact on tāngata whaiora or barriers being erected to exclude family and whānau from being able to support their loved one.

> *And you just don't want you you're afraid of complaining, because you don't know what impact it is gonna have on your loved one in a hospital situation. (Family and whānau)*
>
> *But the worry one has is, that if you in any way as a whānau member, start to show opposition to what's going on or query it, then you're "problem family". (Family and whānau)*
>
> *I just think when we talk about consequences, I just want to acknowledge that most whānau just like whaiora feel really whakama using the services. So when we feel like something isn't tika or isn't okay. We just kind of assume and put it into the box of it's just a Pakeha system during the Pakeha thing. And so we need to feel empowered, as to say this isn't right or this is the views of my phone. No, regardless of whether or not you're Māori or Pasifika, we'll definitely want to acknowledge and tautoko our Asian Whānau. (Family and whānau)*
>
> *Often people are too nervous or scared if they speak up in the way bad treatment. (Family and whānau)*
>
> *This kind of negativity that I've, we've had in the past of not wanting to ever say anything that will upset those people in the services. And that doesn't help you or help anybody, it doesn't help your loved one's growth and understanding that basically, you're looking towards helping someone towards an independent life. (Family and whānau)*

Independent family and whānau advocates

Within the context of confusion, intimidation and fear we heard from family and whānau that there is a need for independent whānau support. We heard that legislation should include provision for independent whānau advocates, the role of which is to assist family and whānau understand and navigate the mental health system, provide education relating to mental illness and the mental health system and advocate for family and whānau at times when families feel their voice has been compromised or mental health professionals do not appear to be adequately including their perspectives. We heard that such provision would assist family, whānau and significant others support tāngata whaiora in the decision-making process. There was also discussion about the need for separate advocates for whānau and tāngata whaiora so that both needs could be supported and met.

> *I think one gets absolutely stuck. And, you know, you need, family need to have support in these circumstances of someone who's on their side who has an understanding of mental illness. (Family and whānau)*

> *I think it needs to be actually clarified that within decision-making, that all the alternatives are explained. And I mean, I know this is going to be very difficult for clinicians. But, you know, our family members have access to the internet. And I know my son had some crazy ideas and a weird sort of analysis when he read about various drugs, etc. So he misinterpreted it. And no one's actually gone back and said, "Hang on, maybe you didn't read that". It's a bit like the sort of anti COVID anti-vaxxers You know, mythology goes around. So we …. when treatment has been given out in terms of anything that needs to be explained probably in stages. This is okay, and then maybe when person has a bit more well, they can have further explained, etc. Not just right at the beginning when they're not really in a state anyway to know what's going on, or be clear enough. And what, what happens is that your client ends up becoming a victim or feeling that they're a victim, and that they have a disability. Instead of being able to be somebody who actually can come to the conclusion that maybe they are recovering, they're becoming more like the rest of the world, they're now seeing the world in a different way. I think that's what goes wrong (Family and whānau)*

> *I think we need a buffer between the families and those that want to apply the Mental Health Act. So a buffer, a peer support person, who can sit in that space to educate clinicians, how they should treat family members can try and make it work. (Family and whānau)*

Advance directives

We heard from family and whānau that advance directives should be embedded in mental health legislation. We also heard that advance directives are essential as they not only provide tāngata whaiora with greater autonomy but clearly articulate who tāngata whaiora would like to be involved, and in what way, with their care.

> *I can't stress enough the importance of having that sort of plan made when someone's in their well space. It's to who can and cannot be involved in their care and who was entitled to receive information. (Family and whānau)*

> *It's just from my personal experiences that every man and his dog wanted to be involved in my mum's care, the first time that she got sick; from co workers to people she meet at a bar or casino and things like that. And it became very messy very quickly. Because there was lots of different voices and not necessarily the appropriate voices. So I don't know how you manage that first time round. It's really tricky. I just know that that did not work for us in what should have happened, as there should have been a plan made when she became well, for what would happen if she got sick again. And that never happen. So once again, the second time that she got sick, there was some taxi driver from Hamilton that she had decided was like her new best friend, and she'd known him for years, but she had met him maybe a week before and he was*

> *heavily involved, in her treatment into care, because she paid him. And so that was hugely inappropriate. And I had staff questioning my involvement as her daughter, saying that I was the one that put her there and she didn't actually really need to be there because this taxi driver friend said she wasn't that sick. (Family and whānau)*

While the provision of advance directives exist, they remain underutilised, and legislation needs to prioritise the development and use of advance directives. We heard from family and whānau about the possible impact of insufficient clinical resourcing.

> *The only issue I can see with that is time to be able to do that clinician time, it's hard enough to get time with a clinician. So to form an Advance directive with one would be fairly difficult. But what I'm saying is if there is one, and it certainly it meets within clinical management, appropriate treatment, it should be followed and not put to one side because it disagrees with the clinicians opinion. (Family and whānau)*

We heard that provision for the development of an advance directive should centre on the needs and wishes of tāngata whaiora. In addition, participants suggested that tāngata whaiora should be provided with support, including a range of people to assist the individual develop directives that address their holistic needs, and that this support is stipulated in legislation. Participants suggested that holistic perspectives should include cultural advisors, clinicians, legal experts, significant others and peer advocates.

> *Also, they are usually produced in a combination with family and whānau involvement to form one of these plans. So to have some form of shared decision-making, yes, is absolutely important. But it is also important to recognize that some people aren't in a position to have family to assist with that decision-making. (Family and whānau)*

We heard that the individual's wishes, as set out in an advance directive, need to be safe guarded. We heard that there have been multiple occasions when an individual's advance directive wishes have been overridden by the clinician(s). We heard that mental health legislation should explicitly state that clinicians are required to adhere to the directions stated in the advance directive, this assumes that the directive was developed from a holistic perspective drawing on multiple perspectives; inclusive of cultural advisors, significant others and peer advocates.

> *If you have somebody who reaches a stable condition, and they produce one outlining their wishes. I understand from that particular initiative, that the services are not required to follow that still, if the clinicians opinion disagrees with the MHAPS plan. So that is a bit of an issue. (Family and whānau)*
>
> *We strongly believe that if somebody does have an advance directive in place, and it's not contrary indicated by any clinical management, it should be followed, absolutely followed according to patient's wishes. (Family and whānau)*

> *But I think it would be terrible if there's an advance directive that has not been looked at as well with, not with the doctors as well. So that it's they're all embodied in it, you know, you can't, if just whānau and the person does it, then and the doctor says, it's not going to work? Well, they should have said that when they first come up with a directive not wait till the next time when there's a real problem. So I think these advance directives need to be kind of made together with the other with the clinicians, and the family and the person. So they all agree ahead of time, and then you don't get into the situation where the clinician says, at that time says, Oh, well, we're not going to follow that, you know, (Family and whānau)*

When there is no advance directive

We heard from family and whānau of situations when an individual with no previous mental health diagnosis suddenly experiences a sudden acute mental health crisis. In situations when there is no advance directive, we heard legislation should require clinicians to enlist the perspectives of the individual's significant others as soon as practically possible.

> *The difficulty we got with those is if somebody has a sudden real, a sudden presentation that doesn't have one of those, you're left without that. (Family and whānau)*

> *In the absence of having that done, my personal opinion would be that the only people should be sort of next of kin, children, parents, spouse, it should be able to show be involved in it persons care if they wish to be placed under a treatment order. (Family and whānau)*

Other family and whānau stressed that in the absence of an advance directive independent advocates are enlisted to ensure the needs of tāngata whaiora are addressed. We heard that independent advocates, in these situations, are essential as it cannot be assumed that the enlistment of family and whānau would be in the interests of tāngata whaiora.

> *But the other thing I think, is really important and the absence of that kind of clear direction our system had some independent advocates or support people who can actually be there for the unwell person to be that conduit, that point of contact with all the people in the whānau or the network claiming wanting involvement and whatever, and actually that person be trained and equipped to make those decisions for the unwell person? Okay. So taxi driver, you're telling me that this person is your best friend and your partner and whatever. But according to x y & z There isn't any evidence to show an enduring continuing relationship. For instance, I can think of another example, you know, neighbours, who know what I do, husband was needing to be sectioned, again, lifelong bipolar, wife was really concerned, when staff stopped talking*

> *to her, because of his own wellness, he was saying things about her that weren't true. (Family and whānau)*

> *Ideally, we wouldn't have to have a paid independent advocate type person. But from, from what I see, I do think there needs to be someone to help sort out that tangle. (Family and whānau)*

RESTRICTIVE PRACTICES

Reduction or elimination of restrictive practices

Participants stressed that restrictive practices need to be contextualised in relation to environments that are inherently restrictive; compulsion effectively removes the rights of tāngata whaiora.

> *I think it's good to think about restrictive practices really broadly. We tend to think about, you know, rooms and things like that, but restrictive practices in those environments, when you find out, held under an Act, just the door that locks behind you. But it's things like access to food, and being able to go and get food when they're hungry. That's not something they can do. Being able to go and have a shower or a bath. That's not something they can do. Those are often locked as well. So when we just think about some of our basic human rights and the decisions we might want to make as an individual in our day-to-day life when we're unwell … That enables people to get a drink when they want one, to have phones when they want it, and so I encourage us to think about the practices in a much broader sense than just simply being detained or the use of a seclusion room. It's all of those things. (Family and whānau)*

Family and whānau participants shared how restrictive practices have been misused and have retraumatised their loved ones. We also heard concern that restrictive practices create an environment of fear and intimidation.

> *And oh, my goodness, I've seen staff nurses bullying and threatening and all sorts of things going on, someone being taken into seclusion and being injected in front of you, bang, you know. (Family and whānau)*

Those calling for removal of restraint and seclusion from mental health legislation stressed that a comprehensive mental health system, coupled with early intervention, would prevent the escalation to an acute level of distress and the need for restrictive practices.

> *I think part of the bigger picture, is access to the resources that people need. Before they get to that point, you know? We're very good at sticking this ambulance at the bottom of the cliff. And that's the conversation we're having now. But, you know, the*

> *bigger part of the conversation and I know that's been hit as well given and I know that's a separate piece of work is making sure we people don't get to that point in the first place. (Family and whānau)*

> *It comes back to the early intervention, if we intervene earlier to prevent people from going into hospital or then what will be seen as those that actually need to be there. (Family and whānau)*

We heard a high degree of support for the elimination of isolation and seclusion.

> *I think isolation and seclusion we all know about the damaging effects on the person when that happens. But I had heard anecdotally also, of instance, this way, they threatened to put people in seclusion, and I tell them that it should they leave the room, they will be put into seclusion. To me, that is one in the same thing, they still being isolated. And we all know, the effects of isolation on people, you know, we social human beings we need we need people to survive. Yeah, again, it's I think it's not a cultural thing. It's the attitude …. But it's again, that the culture in clinicians hold in those mental health facilities and the way they talk to people, I think there are some really, really good people but I have come across some really, really bad people as well. In fact, recently, I was talking to a mental health nurse. And the way she I was really nice, I was asking on behalf of somebody for some support. And the way she spoke to me, and I thought to myself I'm in a good place I'm well, but it really upset me how she spoke to me. And I thought if that is the way they speak to somebody, mental health ward or somebody in crisis, you know, it will just escalate the whole situation, and I think that is why we cannot ever obtain zero seclusion rights, it was meant to be 2020. We will never obtain that until we get the culture of those who work in these spaces. To be better, and I don't know how to do that because you can't teach empathy. (Family and whānau)*

> *Seclusion shouldn't really ever be used, if appropriate management is available. So we're looking at training issues. (Family and whānau)*

> *Seclusion should not be something that needs to be used. (Family and whānau)*

> *In terms of the restrictive practices, I would like to see seclusion designed out of the new legislation. The thing, the only restrictive practices I really give support to is compulsory treatment as a last resort and inpatient admissions. (Family and whānau)*

We also heard support, however, for the rare provision of the individual being physically restrained in situations where the individual might be actively trying to hurt themselves or someone else. We also heard that legislation should explicitly state that the individual should be free from restraint as soon as they are no longer actively attempting to hurt themselves or another.

> *My son died because he was restrained [location]. So I don't think you should allow mechanical restraints at all. Because it's too easy to leave them on. So it's easier to leave them on than to have four people restrain them down. So if somebody really, really if they're actually in the act of hurting somebody else, then yeah, they have to be pulled away. But I think they have to be only people shouldn't be allowing any isolation seclusion. That's, that's considered torture, that makes people crazy. You can't allow that as a treatment of somebody who's already having problems with mental health. So I don't think you should allow seclusion, I don't think you should allow mechanical restraints, and physical restraints. By the nature of them, they can only last as long as there's enough people to keep them restrained. So I think that that's a self fulfilling way of minimizing them. (Family and whānau)*

It is noteworthy that the few family and whānau who supported the rare use of mechanical restraints cited a degree of scepticism around the degree to which poor clinical practices and management have contributed to the perceived need for restraint to be enacted.

> *Restraint occasionally need to use if all else fails, but we do need to be looking at the reasons why it's been used. And if it's as a result of inappropriate management, or lack of education and training for staff. That's not okay. (Family and whānau)*

> *In some instances restraint might need to be used dependent upon the circumstances. That is a real problem. It's a hard thing for anyone to face, it is really awful all around for parents family, for now, the staff who are having to apply restraints upon the trauma caused to the patient and the client. It's a really, really hard thing. (Family and whānau)*

Environmental and workforce considerations

We also heard that practices of seclusion and restraint would be greatly reduced if a number of environmental and workforce considerations were appropriately addressed.

We heard from family and whānau that acute inpatient environments can exacerbate someone's distress. We heard that mental health legislation should require inpatient settings to be designed to reflect therapeutic and supportive environments.

> *From our perspective, when we hear from family we hear the Mental Health Act is often used as a blunt instrument, as a hammer. And I think it gets in the way of a therapeutic relationship. I think our environment has a lot to play … And so where people stay when they need particular care at a particular time, I think is really important. And a welcome supportive environment, that that doesn't feel like this is the last place on earth that I'm going to be. (Family and whānau)*

> *And some of that, too, is the attitude of the staff, we hear from our family, a lot about the attitude of the staff. If staff have a positive regard for family and family we see much*

> *better outcomes for people. Families report the experience has been positive, they were engaged, they were able to be part of a discussion and not just that "It's time to come and pick them up" sort of conversation. And so I guess it comes back to the environment in investing. And then that but also investing in people and fostering that positive regard for people who are seeking to become well, including the whānau doing that. And I think if we can address those that then there's a shift away from the need for restrictive practices and seclusion because the environment itself is going to be therapeutic. The interaction with the staff as always out of the field pay. (Family and whānau)*

We also heard that a lack of de-escalation skills amongst staff can exacerbate someone's distress. We heard that mental health legislation should require all staff to be trained in de-escalation skills and are supported to use these skills. We also heard that the use of de-escalation should be monitored.

> *Time and time again, there are studies that if you have enough de-escalation, people know enough about de-escalation, the use of restraints can be really minimized. (Family and whānau)*

> *One of the biggest thing issues that we have is the misuse of it [restrictive practices]. Quite often as a result of lack of training of staff. There are certain ways and management protocols that can be followed to successfully support and work through someone. Understandably, somebody is in the midst of a violent psychotic episode that is a real difficulty. However, it's really having somebody who has received the proper training, sometimes to defuse and prevent that situation from occurring. So what our members have reported back and from my own lived experience is there has been the use of seclusion and restraint as a direct result of inappropriate management of the illness which has led to it and caused it. So that really needs to be seriously considered. (Family and whānau)*

> *That's the difficulty that we're finding. So it's a lack of training and education, which often results in an inappropriate use of seclusion and restraint. That is a wider issue. (Family and whānau)*

Family and whānau described a degree of uncertainty in regards to the use of restrictive practices for those experiencing substance-related unwellness, namely they were unsure of how to minimise trauma while affording the individual protections.

> *I think when you add things like addiction into the mix, it complicates things further. And you know that that's one of the triggers for psychosis is drug misuse. (Family and whānau)*

PROTECTING SOMEONE'S RIGHTS

Monitoring and review

In the main, we heard mental legislation needs to embed safeguards to ensure that family, whānau and significant others have a direct and immediate means of raising concerns about their loved one's treatment. We also heard about the failure of the mental health system to take their perspectives about the individual's care and treatment into account. In general, family and whānau were not able to offer specific suggestions but rather focused their commentary on the need for efficient complaints processes.

> *I feel that it's important to have some balance, I don't really know enough about the system to know how it will be done. But it just needs to be done. Yeah, but the people need to have a way of complaining. And I don't have a particular thing about exactly how that needs to be done. (Family and whānau)*
>
> *So again, yes, safety nets to make sure that rights have been upheld. And that includes that they've receive treatment appropriate, and support appropriate for their current condition, and presentation and illness. (Family and whānau)*

We also heard that mental health legislation needs to include clinician accountability.

> *That also needs to be accountability by clinicians, when there has been a complaint made and the issues have been part of findings. There must be a change in treatment and there must be accountability that's completely missing. (Family and whānau)*

We heard from family and whānau that the Mental Health Act has resulted in the continued erosion of their loved one's rights. We further heard that they have had no significant or efficient recourse and described current provisions, such as district inspectors, are ineffective in light of their lack of independence. We also heard that district inspectors are problematic as many family and whānau are not aware of their role and that lack the ability to ensure investigative findings are implemented.

> *And I'll jump in with district inspectors. That's probably a big overarching thing. I've been advised by district inspectors, that we've been involved with, they have high powers of investigation, but they have little teeth to be able to implement their findings. That's one issue. It's a high end complex system to navigate, and most people are unaware of district inspectors and their roles. (Family and whānau)*

Within this context we heard from family and whānau there is a need for a mechanism to coordinate complaints to ensure that the rights of tāngata whaiora are upheld.

> *Again, that's why we need to have somebody who's able to coordinate this and ensure that patient rights are being met. (Family and whānau)*

Family and whānau also told us that legislation should require any restrictive practice event to be reviewed “quickly”.

> *If there is a decision made completely by a clinician, it does need to have family involvement. But you can't always do that. If the family isn't experienced in the illness, we are very trusting of the doctors. We rely on doctors. Unfortunately, though, at times, this has not gone well. And so if decisions have been made by clinicians, that also needs to be accountability and again, needs to be a safety net. And there needs to be an urgent and quickly accessible one, not weeks or months of waiting to challenge that decision. So I think it's really important that there is shared decision-making. (Family and whānau)*

Ensuring family and whānau are regarded as an integral component of the individual’s wellbeing and treatment

We heard from family and whānau that mental health legislation needs to include significant others, as defined by tāngata whaiora, as integral component of the individual’s wellbeing and treatment.

> *It needs to be accountability if they don't include family and whānau. And if they don't include them in the treatment plan, because currently there's no accountability and what can you do apart from making a complaint. And a complaint, as we all know, is sapping your energy and making life more difficult for the whole family. (Family and whānau)*

Ensuring whaiora and significant others are informed and understand

We heard from family, whānau and significant others that mental health legislation should include the requirement for family, whānau and significant others to be provided with information, education and resources to assist significant others understand and navigate the mental health system and provide education relating to mental illness.

> *Families are in shock. We don't know what's happening. And we don't know how to access help, but we don't understand the nature of delusional behaviour, or what is going on. So we tend to often take accusations personally, etc, and not understand that this is part of a bigger perception for the person. So to me, I think we really got to get into a situation where there's better education for families, on all levels. Understanding the nature of mental distress. … I go to quite a lot of support groups, and I realized that a lot of family members just don't understand what's going on at all. And even though it's repeatedly told to them by various counsellors, etc, it's very hard to understand what is going on and another person's mindset. (Family and whānau)*
>
> *And I just wish there has been education. (Family and whānau)*

> *What that looks like as more gentle support, but also more education. So we sort of know what we're working for working with, (Family and whānau)*

Independent advocates for family, whānau and significant others

We heard that power imbalances that privilege clinicians can impact on the wellbeing of tāngata whaiora and that of family, whānau and significant others, resulting in a sense of confusion, intimidation and fear. From family and whānau we heard that mental health legislation should include the requirement for independent advocates who support for significant others at times when families feel their voice has been compromised or mental health professionals do not appear to be adequately including their perspectives. We heard that such provision would assist family, whānau and significant others support tāngata whaiora in the decision-making process.

> *I think that is the problem it's in the communication has broken down between the family and the clinicians. They are the ones that work in this space, they're the ones to recognize that we are in distress, that this is the first time this has happened to us and that we need support. And if they can't do it, that they need to appoint somebody that can work with us. (Family and whānau)*

> *There needs to be somebody in the community that is actually an advocate for families. I know we have family advisors, but that isn't working well. If you have a problem there is no one at the moment.… I don't think contacting a committee is going to help anybody. Because very often my needs for help are almost immediate, you know, within a few days. (Family and whānau)*

We also heard that such independent advocates should be made available seven days a week and after hours.

> *Well, heaven sake, where do you go for that kind of assistance. It's not okay to wait until Monday morning or wait for some completely unknown person in the crisis team. So there's not you know, there's not a 24 hour service seven days a week which needs to happen. (Family and whānau)*

APPENDIX 3: MĀORI MENTAL HEALTH SECTOR

CONTEXT

We heard from the Māori mental health sector that there is a need for mental health legislation be made more relevant, more tāngata whaiora and whānau focused and inclusive of culturally relevant perspectives. We also heard, however, that there are a number of complicated issues.

Many participants acknowledged that Māori are disproportionally represented under the Mental Health Act. There was also a strong view that this occurs because of racism, cultural bias, lack of understanding of Māori culture, and a system that privileges a western biomedical worldview. We heard repeated concern about the inherent bias of mental health professionals and that Māori have been disadvantaged through use of the Mental Health Act. We also heard that many Māori were being placed under the Act for longer periods of time than non-Māori.

> *I feel like the Mental Health Act has been used because staff get frightened of us. The staff that initiate the act have the authority and at times it feels like they abuse this authority. The use of seclusion and chemical restraint without regard for our cultural and values is demeaning. I suppose it is what it is. Our family, experience racism and discrimination, from the time we enter mental health services. The compulsory treatment pathway does not include us, and respect who we are. (Mental health sector, Māori).*

> *if you get a big person, like a great big, strapping man who's like, six foot tall, (similar to one of my own brothers) he's distressed and walking into the inpatient area, This journey can be intimidating for people, actions can be misconstrued, And, you know, that its potentially, going to be a tough journey. A lot of our people, by default, go down a different pathway, I think that there are times when compulsion is useful, however there are issues with the way it's implemented. Engaging with Māori who are distressed, threatening, or, you know, if they're not comfortable in that setting, then there needs to be consideration of practices that are acknowledging and helpful. (Mental health sector, Māori)*

> *I have seen Māori who continue to be under the Mental Health Act for 10 plus years, and on the other hand we see Pakeha on the Mental Health Act for six month! that really annoys me. (Mental health sector, Māori)*

We heard that, to some degree, the disproportionate representation of Māori being placed under the Mental Health Act can be understood in light of the mental health system being in crisis.

> *The pressures that happen within the system. We [mental health] are often the people that get rung by families, GPs, emergency departments, Joe Public, all the people just come up to the ward and ask us [Maori workers] to fix people. So that's another problem. So you have psychosocial issues, community issues that are going on. So we're living in a really difficult time where the services have been either understaffed, underfunded, our hospital systems are not meeting the needs because they don't have enough staff or they don't have a culturally appropriate environment. (Mental health sector, Māori)*

We heard that the Mental Health Act is sufficiently ambiguous to result in varied and inconsistent application. Differing interpretations and applications of the Act is evidenced in differing application by DHB and ethnic groups. As a consequence, we heard that new legislation needs to ensure consistent application.

> *The history of the Act, is interesting in that we know that the data show's that Māori are secluded at far greater rates than anybody else. The level of coercion is high for Māori. The behaviour of staff and the structure of systems appear to not support a reduction of the rate. . (Mental health sector, Māori)*

We heard that the Act has been used as a punitive measure, often to control and punish tāngata whaiora who are not deemed compliant or appropriately responsive to health professionals.

> *Now, we were just talking about the Mental Health Treatment and Compulsory Act. And that states in Sections 29 and 30 inpatient and community treatment orders that the Act says that the person must be compliant and needs to take the medication. Also people stay under the Act (and or the practice of staff to keep people under the act, is only so they can access free medication. Therefore, that's what the Act is supposed to do. However, there are punitive behaviors by our nurses, by our staff on the unit in how they enact that Act. Therefore, you know, when our whānau don't listen, they become demanding, the first thing they reach for is that blinking Act to incarcerate our whānau. (Mental health sector, Māori)*

> *Now in the community, it's used in another way, what they do is that if our whānau don't whakarongo, and don't want to come to be treated, they [the staff] use the police to help move our whānau out of their house, out of the papakainga or wherever they are, to be taken off to an institution. (Mental health sector, Māori)*

> *It certainly feels like the Act is used by those who make themselves powerful, by those who do not regard it as an can be more destructive to the wairua of our tāngata than it is helpful. (Mental health sector, Māori)*

We heard that the mental health system was originally established to cater for people to be taken out of society. We heard society had a fear of contamination from mental disease and also a massive denial that it even existed. These concepts were alien to Māori people whose whānau members suffering from trauma were always included within the whānau.[4] We heard that tāngata whaiora Māori and their whanau have been better served throughout the 1970's and 1980's. We heard that there are considerable lessons from this development; specifically the cultural alignment and integration of te ao Māori practice within mental health systems.

We heard that the early Māori nurses working in mental health services were pioneers. We heard reference to Winston Maniapoto and Bob Elliott. Both played central roles in transforming the mental health system. In these days mental health services were largely services by big institutions; it wasn't until late 1980's – 90's that we saw the first kaupapa Māori services emerge. We heard of the role that the first Mental Health Commission (1996) had in facilitating these changes.

An inquiry in mental health services in the mid-1990s (the 1996 Mason Report) resulted in the establishment of the Mental Health Commission (the Commission). The Commission advised the government, facilitated and carried out research and worked to reduce discrimination against those with mental illness.

We heard that the current crisis in mental health responsiveness has coincided with an erosion of kaupapa Māori services working in mental health and addiction settings. Participants also raised issues with the reduction in whānau support workers as having had a significant impact.

> *When I think back to when the Act was initiated in 1991. And throughout the country, we saw the establishment of kaupapa services working within a crisis context. And I have to say, you know, even though I'm constantly looking backwards to find solutions in the present and moving forward, and that some of that development that was happening back then certainly enabled that choice of process to occur ahead of the mighty practitioner - granting the individual first, before the crisis worker came. (Mental health sector, Māori)*
>
> *Do you know one of the other things that happened, why kaupapa services were flourishing back then, was the Blueprint and the work of the Mental Health Commission*

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[4] Māori Health Transformations (Kingi, Durie, Elder, Tapsell, Lawrence and Bennett) Huia Publishers 2017.

> *required that they established kaupapa Māori mental health services. That, and even defined it for a population of 100,000. There's to be X number of Māori health workers, X number of kaumatua and kuia. They defined what that needed to look like. And I think what we haven't seen is the monitoring of the implementation of that and the ongoing development of it. And so, when that happened in the 90s - 2000s, and then we became quite risk adverse as a system. And what became more important was about managing risk. And a system not considering kaupapa services has been something that could indeed manage risk. But more, do these Māori practitioners have qualifications that can sit within a risk environment? And I think that's where we began to see some of the demise of what was indeed a flourishing environment. (Mental health sector, Māori)*

> *Back in the day, in the 90s, was probably the most flourishing time for Māori in mental health. Kaupapa services worked in partnership at all levels of the system. Sadly, today, it's not quite the same. And I think when we lose that leadership, when we lose Māori working in all positions, like yourselves, we can also see all of that wonderful work just go. (Mental health sector, Māori)*

> *But we need someone to do the job. We used to have very functional kaupapa Māori services, we had respites, you know? (Mental health sector, Māori)*

> *It's not just the main system that we need to transform and change. How do we develop our Māori systems to be able to be acknowledged, to be able to do some of the work? (Mental health sector, Māori)*

We heard two primary voices amongst Māori working in the mental health sector. The first cohort spoke strongly about the need to embed Te Tiriti within new mental health legislation. The second cohort stressed that the wellbeing of tāngata whaiora and their whānau can only be achieved by devolving service provision to Iwi, hapū, Māori community-based services providers and kaupapa Māori services.

> *But in terms of the legislation, I think there needs to be something stronger around this idea of devolution. Devolution of services to Māori. There needs to be something in there about tino rangatiratanga because, it's important to train the workforce and work with our colleagues. This development takes time we need to start shifting the resources and devolving the services to support Maori to deliver by Māori for Māori. You know, if we want to make some real change we can't keep working in the current system. If you continue to deliver the same as what we have now And so that's what I am saying, there needs to be something stronger either in the legislation and or in the service development framework that works with the legislation, that says that there's a pathway towards devolution. How do we implement Te Tiriti o Waitangi, enable Maori tino Rangatiratanga. , I'm not even going with the treaty principles, I'm going with Te*

> *Tīriti , tino rangatiratanga, or, you know, by Māori for Māori solutions, you know, and that includes resources and the funding, and us being able to do things in our own way as being able to reclaim how we do our things with mātauranga Māori, it needs to be much stronger than what it does now. Because at the moment, you know, it is about working with Māori and this partnership, but we've tried that, we've tried that process before, though, it's time for us to, to, to be able to, you know, express our tino rangatiratanga and I can tell you, all the issues that we've been talking about will be resolved, because a lot of the time it's just negotiation, this back and forth, and that, you know, and then the ultimate sort of power and the decision making, you know, you know, stays with the institution. (Mental health sector, Māori)*

We heard that whānau is essential to the wellbeing of tāngata whaiora. We also heard that definitions of whānau should include young people and children. Such inclusion acknowledges that young people and children, and not exclusively adults, can provide support. We heard we need to consider the life course when we consider whānau.

We heard that a substantial amount of mental health professionals' perception of risk and non-compliance was because of the health professional's failure to appropriately engage with tāngata whaiora and the whānau.

> *It has been quite striking, how we really disempower tāngata whai ora and their whānau. Just by the mere conversations, we start off with can disempower them. We strip them of their dignity, and the Act right alongside their korero supports that. I'm not impressed with the Act. Even if there are Māori psychiatrists saying there's nothing wrong with it. But I still say that it's not a good thing to have around. If you're disempowering someone …. who gave you this right? You take away the mana of someone, just because he's unwell. And that Act does it because it sits alongside that clinician who is going to do something with their whānau, not even kia ora or mihi to our whānau. So what x is saying the front door is important. (Mental health sector, Māori)*

SYSTEM AND SERVICE FRAMEWORK

From Māori in the mental health sector we heard recommendations around changes to the mental health system that would significantly reduce rates of compulsion.

We heard the need for sufficient resourcing and coordination to enable tāngata whaiora and their whānau to receive comprehensive services. The provision of early engagement with comprehensive services would reduce the risk of escalating mental distress that might result in the individual coming under the Act.

We heard one measure of a successful Treaty partnership would be equitable provision of Māori staff and Māori managers within the health and mental health care system.

> *You know, it's really lovely. I hear it all the time. That the Tiriti is respected and understood "we are onboard with the Tiriti", "we support the Treaty", we hear all those beautiful words, but never where are our Māori staff? Where are our Māori managers? Where are our Māori on the grassroots? (Mental health sector, Māori)*

We heard that there is a need for the Service Development framework to address racist and discriminatory practices amongst staff, including monitoring of services.

> *We need Duly Authorized Officers to be free from racism and bias, that they don't make judgments and or assumptions about the people that they are there to serve. Hey, because if we think about the people that are involved in implementing this Act, that has to be one area that needs to be considered. (Mental health sector, Māori)*

We heard all clinical staff need to be trained to provide care to Māori tāngata whaiora that is culturally safe and competent.

> *The workforce needs to be trained in a different way to deal with us rather than out of fear. Part of that has to do with employing people from overseas who have no understanding of Māori. No understanding what that means, and get frightened of us in front of our big men, and you know, all that sort of stuff. So this is our why I say that the Mental Health Act is used out of fear of their staff, and lack of training rather than that we need it. (Mental health sector, Māori)*

We heard that assessment and service provision needs to view tāngata whaiora holistically and remove artificial classifications that result in siloed and disparate service delivery.

We heard inpatient environments should be designed around the holistic support and cultural needs of tāngata whaiora and their whanau.

We heard that a shift in focus away from compulsory treatment requires moving away from a reliance on dominant western biomedical models which has resulted in the singular privileging of psychiatry. We further heard that many parts of the social, justice and health systems are siloed which means the individual and whānau face insurmountable barriers engaging in preventative support and early intervention. We heard, as a consequence, our current mental health system has developed a focus on crisis intervention rather than prevention and early intervention.

> *Currently there are the silos across agencies, and looking more at the distress in the continuum, and not at the other end, where it's likely to be way too late to be able to do anything to support the person before they need treatment. (Mental health sector, Māori)*

SHOULD THERE BE COMPULSION?

We heard from many in the Māori mental health sector that there is a need to have some provision for compulsion. We also heard that mental health legislation should stress that compulsion is a last resort only. Notably, no consensus was communicated over how “last resort” might be defined.

> *She acknowledged at times she didn't need to be under compulsory treatment, because she was so unwell. And that if there wasn’t compulsory treatment it could have been really unsafe for her and her family. (Mental health sector, Māori)*
>
> *It's good to have an option, I think an opportunity for compulsory treatment. This is my own personal view, because I think the right times when whānau, you know, are really struggling and their loved one isn't, you know, isn't in the in a good space - so having an opportunity, I suppose, to have options available for whaiora is a good thing. I think, you know, and I speak from my own whānau experience with that. (Mental health sector, Māori)*
>
> *I don't have a problem with the Mental Health Act. The reason we use the Mental Health Act is very specific. When we don't require it, we take someone off it, we prefer people not to be under the Mental Health Act. From my perspective, I only ever use it because I require it. And the reason I believe that I need to use this when I think somebody is struggling, and they need help. And they're struggling to make a decision around what might be helpful for them to do that makes him either be less risk to themselves, or less risk to other people. And so the other thing that I think's been useful the Act is its second arm, which means that when people are really, really struggling, we can intervene. And typically, that's because they're struggling with the ability to make some sound decisions around the capacity to make good decisions about their own well being. And that's often driven, not only by what we're seeing, but by family and the community. If a person doesn't require the Mental Health Act we take them off. And I certainly have been somebody that takes people off the Mental Health Act when they don't need it. So most people, majority, are not under the Mental Health Act. (Mental health sector, Māori)*

From two cohorts within the Māori mental health sector we heard differing perspectives cohorts about how compulsion would be significantly reduced.

First, we heard that tāngata whaiora and whānau would be better positioned to receive preventative and holistic care through mental health and health care in general if services were devolved to Iwi Māori and kaupapa Māori services. We heard that such devolution should be embedded in new mental health legislation.

> *Let's give them the mana back to Māori providers in the community. Let them have a go. If it's about changing the way that we do things, empower the whānau in the*

> *community to do it. We can support them. Let us [DHB] be the secondary service that we're supposed to be. Let whānau out in the community, look after the whānau provide the support the funding that should go towards the whānau out in the community to do their mahi. They won't disempower our whānau they'll have the right words to say to our whānau… So no, give it back to the Māori providers, they can do that mahi, and they'll do a better job than us that's for sure. (Mental health sector, Māori)*

The second cohort focused their commentary on improving the current system. This cohort stressed the need to shift the compulsory focus of the Act to universal engagement, treatment and support of tāngata whaiora and their whānau. We heard mental health legislation should stress the need for early intervention and wraparound services "We tend to wait until they fall off the cliff and then deal with it through compulsion". Such provision would assist people access support early and greatly reduce the compulsory treatment embedded within the current legislation. We also heard that this would require a financial commitment from the government and that new legislation should provide this direction.

> *We believe that if we make mental health and addiction services more readily available in the community, by a variety of mechanisms, so you know, youth streams, more visibly available, addiction services and more visibly available because most of it, you know, historically with hidden mental health and addiction behind us, whereas what we're saying is that we need to make it more upfront, so that people are actually accepting their distress as part of everybody's life. And so if we deal with that earlier, then we're less likely to require compulsion. But we believe that whānau bring a strength and whānau we define as actually not just being blood relatives. It's the friends, partners, significant others in our life that have helped us journey to the point that we've gotten to. So it's actually involved in all of those people's standing alongside the person with the lived experience, that's going to be significant, make a difference to them. (Mental health sector, Māori)*

> *But I think the biggest thing for me if there's no compulsory treatment, will be a really powerfully empowered and enabled community of health care workers, but whanaunga to be able to identify those situations and also have the tools to combat them, I think, as well, working in a very integrated health system and social system and justice system. (Mental health sector, Māori)*

> *And I also think that there needs to be more preventative stuff so that we don't end up going into crisis and then acting out. I guess that's what they would call it when we get into a space where we are just such extreme that we start acting out and then their fear kicks in. (Mental health sector, Māori)*

> *What are they doing in primary healthcare , so hospital systems, or do secondary and tertiary. So that's a whole different ballgame of the type of patient and severity or*

> *whatever situations happening. So that's the other thing, when you think about the, which aspect of the system that person's coming into, depends on the way that people are responding. And if someone's behaviors mean that other people don't feel safe, then there's a number of ways that you respond to that. But typically, in the primary sector, that's not the kind of person that they're dealing with. Only , 5%, of our whanau end up coming through this system and need to come under the auspices of the Mental Health Act, and that whatever happens on an inpatient psychiatric unit, or community mental health, so we just could get get that get that that mindset where we have most people around the community most people are have are accessing non government organizations, Māori organizations, community promise services, is it smaller percentage that come through the system. And it's, it's interesting a die, you know, if there's, if we do intervene sooner and because already think of what the water is showing a huge reduction in the numbers of admissions into an acute setting, because of the way that that's working. And if we can model that type of kaupapa activity throughout the secondary and tertiary system, surely, we should be able to make a difference a and then at the public healthier and more energy focused on that. So we can sort of totally reduce any impact of the drivers that that contribute towards mental illness, you know, we should get somewhere, but a long way to go. Any other Ricardo about the home protection. (Mental health sector, Māori)*

We heard that a shift in focus away from compulsory treatment requires moving away from a reliance on dominant western biomedical models which has resulted in the singular privileging of psychiatry. We further heard that many parts of the social, justice and health systems are siloed which means the individual and whānau face insurmountable barriers engaging in preventative support and early intervention. We heard, as a consequence, our current mental health system has developed a focus on crisis intervention rather than prevention and early intervention.

> *The elimination of compulsion, just off the top of my head, would be an environment or a whole of agency approach, and I'm not talking about only health. I'm talking about social settings, talking about justice, talking about health, talking about all of it. And the recognition of an environment that is unapologetically tikanga and te ao Māori and of an approach where people are valued as who they are, and the environments in which they shaped them, and the value of, you know, that tikanga being at the same level of medical associated restraint technique. (Mental health sector, Māori)*

IF THERE IS SOME COMPULSION WHAT WOULD IT LOOK LIKE?

As discussed previously, two cohorts within the Māori mental health sector were identified: those who advocate that mental health services need to be devolved to Māori and those who focused their commentary on changes that are required to the existing system. In the main, the following analysis is based on the latter cohort's input as a shift to kaupapa Māori service provision and te ao Māori models of prevention and intervention implicitly embed the following suggestions, namely positioning the individual's rights, health and wellbeing within a context of their wider social support structure, albeit whakapapa whānau or significant others and the provision of culturally appropriate care.

The centrality of whānau

We heard from Māori in the mental health sector that whānau are essential to the wellbeing of tāngata whaiora. We heard that such a holistic focus means that a collective notion of self needs to be included in mental health legislation to reflect whānau as an essential component of engagement, decision making, advocacy and support.

We also heard that mental health legislation should specifically acknowledge children and young people within definitions of whānau. Such inclusion acknowledges that young people and children, and not exclusively adults, can be provide support.

> *As a child, my mother was sectioned several times, I knew nothing of what was going on. Partly the system, and the children excluded from anything. Hopefully, my father who didn't know, who was a bereft. And so I do think somewhere, children need to be considered in the process of it. (Mental health sector, Māori)*

We also heard that mental health legislation should acknowledge that the wishes of tāngata whaiora about the inclusion of whānau as paramount. We heard that this is important because it cannot be assumed that all tāngata whaiora have a positive or supportive relationship with their whānau. We also heard that mental health legislation should explicitly state that provision for significant others, as defined by tāngata whaiora, to be part of the decision-making process.

> *One thing I'm always cautious about is that the whānau that are actually involved in the care and support of the service user … that it's a healthy relationship. Because my experience in my own whānau is that that's not always the case. (Mental health sector, Māori)*

We also heard that tāngata whaiora are part of a family system and mental health legislation should include provision to support the whole whānau; the rationale of which is that whānau often provide support to their loved one, which can have an impact on their own wellbeing.

> *Some of our whānau are getting tired of looking after our whānau. … What is our role to ensure that it's the whole whanau. So looking at the whaiora in the context of*

> *whānau, not as an individual? So therefore, how's the whānau doing? Are they doing okay looking after this particular individual? If not, why not? What are we doing that we need to do to put in place for their whānau? What are some of the processes or systems that can support the whānau to have a bit of relief or reprieve or respite by themselves so that the tāngata whai i te ora is still getting the best care that they can. Not all whānau can hang out and stick it out. Not all whānau can do their job well. And there are those that can do it. But they've got strategies in place. And only they know how to do the mahi that they want to do for the whānau with the kōrero of the tāngata whai i te ora of course, but sometimes, we just need to be a little bit more respectful in how we ask these questions of the whanau. How can we help? What is it that you need? And it certainly ain't to go back into the institution. (Mental health sector, Māori)*

The need for support and respite was especially noted for older whānau members.

> *What else can we do to look after the whanau? They've got to do some good work, looking after our tāngata whai te ora is, you know, sometimes parents are getting older too. And so, what is it that we need to do to support the pakeke whānau? Who does the activity to help look after their whānau, if they're under the Act? What does that look like? How does it come about where the whānau can be cared for in a way that is safe, that they've had respite, and then they can come back rejuvenated to manaaki our whānau. (Mental health sector, Māori)*

Provision for culturally appropriate responses

We heard that prejudice and racism have underscored mental health assessments of tāngata whaiora, whereby tāngata whaiora have been placed unnecessarily under the Act. We heard that this has occurred because of either a failure to engage in de-escalation processes or a lack of knowledge about how to engage in de-escalation. We equally heard that a disproportionate number of Māori have been placed under the Act because of mental health staff lacking cultural knowledge and failing to engage tāngata whaiora in an appropriate manner.

We heard that processes leading to someone being placed under the Act can be rushed and decisions are made without the input of whānau and cultural expertise. We heard that the inclusion of the perspectives of whānau and those with cultural expertise will ensure sufficient context is provided to contribute to appropriate decision making. We also heard that a model of care needs to be implemented that is founded upon respect, time taken to know the individual and understanding their life course (whakapapa) and needs.

> *Wairuatanga and te ao Māori, we need to understand a person's whakapapa. What is his worldview, of who he is? How does he reflect his maunga and what it means for him. The same with Te Tiriti, when you interact with our whānau in [location removed] I*

> *use it regularly as a point of way to te ao Māori. Like I said it's about the knowledge of Māori. If you understand his story. That means, this tāngata whaiora's story means a lot to him, it means a lot to him to tell you his story. Takes him a long time to talk about it, not just about his medication and the scientific diagnosis you gave him. This is about who the tāngata whaiora is. I bet his koroua is a chief of areas around here. But you haven't given him the option. Then you will see the man for who he is. Those are the kinds of things that ring true for me about knowing te ao Māori, knowing about the whakapapa of someone, and even making connections to maunga that they, that you associate with. Perhaps this guy didn't grow up at home on his papa kainga of his great great grandfather but what he calls home, that's his turangawaewae, that's him, this his whakapapa and we need to honour that. …(Mental health sector, Māori)*

Cultural assessments

We heard from Māori in the mental health sector that the privileging of western biomedical approaches has marginalized Māori. While Section 5 of the Mental Health Act makes provision for the respect and acknowledgement of the cultural needs of a person, we heard that such provision is vague and has been inconsistently applied across the motu. As a consequence, we heard that mental health legislation should stipulate how respect and acknowledgement of an individual's culture might be actualised.

We heard that, while cultural assessments are not a legislative requirement, they are essential to provide an appropriate understanding, context and lived experience of tāngata whaiora and whānau.

> *Our whānau absolutely deserve to have those cultural assessments sitting alongside them. They open up and tell the story, because what we don't see as a narrative that's, you know, the wider narrative and the deep narrative and that they too though, shouldn't just be the add on, you know, in the bar of, of what should be coming across. We need to set there as well so that they don't end up in some someplace without you know, someone's been appointed to do this week but actually isn't a skilled enough to do it in. So the and then they do a disservice to the people. So again, you know, but absolutely total. (Mental health sector, Māori)*

We heard that mental health legislation should require the provision of such assessments and that they should be linked to protection-related Treaty obligations.

> *The legislation actually doesn't require the cultural assessment to be there. We need legislation to require them to ensure that a te ao Māori perspective is presented on behalf of Māori in front of a judicial process; that there was some adherence to the kaupapa Māori principles in terms of participating in practice, or in partnership for the*

> *protection of rights of Māori when they stand before the judge. (Mental health sector, Māori)*

> *Cultural assessment and cultural content should be mandatory in reports. Because a lot of them - and information is even missing - are visibly not seen. Even in reports that are presented, you know, people might be identified as Māori, but that's about it. So it doesn't really, the report, doesn't really do true justice to who that whaiora and their whānau are, the majority of the time. So it would be great to include cultural components, and their processes and their assessments as just routine. (Mental health sector, Māori)*

> *And if we are to introduce through legislation having a requirement to have a cultural assessment or a cultural report like that, we really have to pick our game up and be more smarter with regards to the way that we work. We need to actually look at the whole person. Why is there no cultural report from a te ao Māori perspective, from a mātauranga Māori perspective, present when [cultural / peer support worker] stands in front of the courts? When my other peers and that stand in front of the courts? Because that's what's been missing. (Mental health sector, Māori)*

We heard that there is a need for equivalency, in terms of cultural assessments, across legislation and the same requirements should be reflected in mental health legislation.

We heard however concern that there is a high degree of variable quality across cultural assessments and there is a need for assessments to meet quality standards.

> *Cultural assessments are presented by practitioners who have varying ability, and skill. The level of skill will indicate whether the report is of good quality. And if you're thinking about an individual in respect of all of those things, of the seen and unseen when someone does a court report, you need somebody who understands it from the realm of the psychological and the social setting. So that it sits within and becomes part of, often what I've seen as a separate report. So, all the, some of the reports I've read, have just been copies of what I've done. So, the person has cut and pasted what I did and put it in the report, and then put that up. And it's worrying for me all the copies of what someone else had done 3, 4, 5 years ago are in the report. (Mental health sector, Māori)*

We heard that cultural assessments would have greater utility if they include psychological, cultural and spiritual considerations.

> *But when you're asking for it from a mental health psychological perspective, as well as cultural, it's not separate culture and spiritual, all of it is part of the individual normally to be interwoven. I think that it becomes difficult if we think of it as being a separate entity, it needs to be all done together. (Mental health sector, Māori)*

We also heard that current utility of cultural assessments is limited given the fact that they are commonly viewed as an “additional document” and not used as a basis for a discussion between interested parties.

> *So I think that they are important. They are important when they become useful, and the only way they become useful, not as an additional document, but that we sit down and we talk. So often, when I've seen these reports, you've done separate, I can't find them, I have to go and look for them and the people to like come and talk to them. Or I asked a person, ‘Did you see this person?’ And even their quality of engagement is concerning. And then every now and then you have someone who can do a particularly good role. (Mental health sector, Māori)*

We heard that variable quality of cultural assessments can be attributed to a dearth of people available to draft cultural reports

> *So I think the difficulty is, is we don't have enough people to do the role. So if we are going to fulfill that role, we need almost the equivalent of a committee to meet your health service, you know. Like, you can expect one or two people to do the role of what we're expecting. Because generally the service, particularly down this way, you've got at least 60% of the people you're serving are Māori, then you've got the complexity of distance and location. So some see you. (Mental health sector, Māori)*

Court engagement

We heard that court-related processes are intimidating for tāngata whaiora and whānau. We heard that judicial processes need to be person and whānau-centred and above all adhere to mana enhancing practices and that mental health legislation should make provision for such practices.

> *You know, at the beginning stages, the individual has to front up to a district court judge. And even though those court hearings may well be heard within a mental health setting, there's still a judicial process. You have to stand when the judge walks in the door. It’s a very Westminister process and there has to be another way that we can do that. So that there's a level of comfort and confidence with the people that we're there to serve in that process. (Mental health sector, Māori)*

Mental health workforce

We heard from Māori in the mental health sector that mental health staff lack cultural competency, which when coupled with the predominance of western biomedical models continues to result in the misdiagnosis of Māori as possessing a mental health disorder. We heard that mental health legislation should require mental health providers to demonstrate cultural competency.

> *I have a referral from a friend, a psychiatrist who is Pakeha, to see this person because she suspected was schizophrenic. The tāngata whaiora had very strong cultural and spiritual belief systems that did not fit schizophrenia or psychosis or mental illness. She didn't have an illness. So I discharged her from the service. It's a problem you've got someone on tape breathing well as normal, and she might be slightly on the skewed end of the spectrum, but it still sits within what's normal for us. But, you know, here she would have ended up in the anti psychotic or the diagnosis of schizophrenia, which he doesn't have. (Mental health sector, Māori)*

> *So sometimes people are getting misinterpreted. The same something the meaning is not that it's been misinterpreted by somebody who's not doesn't hear the way that we're here. So you might have seen someone who comes from South Africa, here's something that one of our young fellas is saying, and it's not enough meaning what they think that he said he's not actually a risk, but he's really annoyed at something and he just needs someone to listen to him. But he needs to be listened too, and in the right way. And those are the skills that need to be grown. Those ability of clinicians to admit where I need more money and the system And that's when you come up to capacity that complexity sits there again because the person hearing doesn't understand and they're both talking English and I don't even have to be speaking in a different language for not picking up the same thing. Am I making sense? (Mental health sector, Māori)*

Time limited

We also heard that compulsion should be time limited and that this should be clearly stated in the legislation.

> *Compulsion should be short lived. Control and compulsion should be according to a person's needs rather than the system's processes. (Mental health sector, Māori)*

TE TIRITI O WAITANGI

From the Māori workforce sector we heard that mental health legislation needs to embed the articles of Te Tiriti and the relationship to kawanatanga, tino rangatiratanga and ōritetanga and acknowledging the person's connection with their wairua, values and beliefs from a te ao Māori worldview.

> *Te Tiriti o Waitangi. Be careful whānau because that's been exploited by many services and people throughout Aotearoa New Zealand, with a lack of understanding for me. If I was to look at Te Tiriti, what I look at, I look at the articles. The articles to me have more weight than the principles itself. (Mental health sector, Māori)*

> *I also hope that when we do embed Te Tiriti o Waitangi we embed the Māori version. That way, we'll have a stronger voice in terms of how the articles run out. (Mental health sector, Māori)*

We also heard that He Whakaputanga (Declaration of Independence, 1835) needs to be included in legislation as the founding document of Aotearoa New Zealand. We heard that this is especially essential because He Whakaputanga reinforces the rights of tino rangatiratanga.

> *The other thing, of course, is He Wakaputanga. He Wakaputanga is the founding document. It's the tuakana to the Tiriti as far as I'm concerned. He Wakaputanga was giving hapū our tino rangatiratanga. It said we determine ourselves. And now I think for me, my thoughts are, that the Treaty and He Wakaputanga were signed because the tūpuna would know that we would need it today. (Mental health sector, Māori)*

We also heard that mental health legislation should be drafted with reference to the United Nations Declaration on the Rights of Indigenous Peoples.

> *I also think I'm really quite, you know - Te Tiriti, you know, we talk about equity. Well, if you are, you know, human rights, or what about Indigenous rights? I know we've got Te Tiriti but why isn't Indigenous rights identified there? You know, so for me those are some of the things that are really important to my heart in regards to this stuff so I guess that's, you know, that's just a very just a brief whakaaro of what governs me in the mahi that I do. (Mental health sector, Māori)*

We heard that there is a need to appropriately support people's oranga tonutanga. A number of failures within the wider health system has resulted people experiencing mental health challenges to receive support early and, as a consequence, their situation worsens to the point that they encounter mental health services in a time of crisis.

> *So from our regional perspective, we believe without a compulsory treatment Act will require quite a lot of significant investment in early intervention, wraparound services in the community dealing with distress - acting earlier than what we currently deal with it. We tend to wait until they fall off the cliff and then deal with it through compulsion. (Mental health sector, Māori)*

> *Rather than a last resort mental health option, we heard that the focus should be how to support tāngata whaiora in the widest sense of their wellbeing.*

> *The Act will be invoked by those who make themselves powerful by those who do not regard it as an instrument to support my whānau. Because it's more destructive to the wairua of our tāngata than it is helpful. (Mental health sector, Māori)*

> *Nourish the wairua of our people, they encourage the growth, to develop who they are in their own space, their own land, and, and their own whānau to who they can be, and be part of society. (Mental health sector, Māori)*

To achieve this we repeatedly heard that there are a number of central te ao Māori tenets that the new legislation should embed.

Te Ao Māori Tenet	Description	Quote
Tino rangatiratanga	There is a need to ensure the legislation provides Māori with the ability to develop their own kaupapa Māori responses, namely Māori addressing and responding to the needs of Māori. We heard that a kaupapa Māori response reflects articles of Te Tiriti which give protections to the rights of Māori for their own parallel responses. We heard that this requirement is in response to the privileging of western medical models that have been imposed with the exclusion of Iwi, hapū, Māori providers and whānau. We heard that communities should be empowered to develop their own responses. We heard historically our	*Because I think we tend to think more about the hospital because we're so colonized, not just me, but the whole whānau, the whole of Aotearoa Māori are colonized. We believe that the right place for a whānau to go is a hospital. But it ain't the right place for that, because there are several layers to the hospital before you get to it. And those people that are part of those layers, cause more harm to our whānau than good. If we're talking about the right levers and talking about a workforce, and we're talking about funding to develop a workforce, just leave it to the community and build the community, the workforce in the community to look after our whānau, not us. We have a secondary… leave us alone in that place the Pākehā has made for us to ensure that we can look up their follow up and then we don't do a good job in it. Because the systems just really impact on us. And it's so white, the structure. It just takes so many crowbars to pull it apart. But just getting back to the good stuff where our whānau are, truly, I believe are the key to what care our whānau need. (Mental health sector, Māori)* *The problem is that western models are privileged at the moment, you know, and Māori are sort of like the nice to do stuff, you know? The success of our COVID response a move away from what I would call professionally-led where community has had to fit into that model. What we have seen during COVID is the success of community-led where the professionals, the experts, fit in with the community. So, it's a complete flip around of how we've been doing things for so long, you know, and that's why I say we've got the capability. We haven't got the capacity yet, you know, we're still, you know, our Māori workforce, you know - obviously, we need more people working in key positions, and we just*

	responses have been professionally developed and led, reflecting the privileging of western medical models, but these approaches have not been successful. We heard that there is recent evidence for community led responses in light of community responsiveness to COVID-19.	*need more people working in workforces, but we just don't have the numbers. Even if we did that we still wouldn't have the numbers, you know. So it's much wider. (Mental health sector, Māori)* *I am of the view that the only way we can truly have tino rangatiratanga is by being Iwi-driven, Iwi-led and Iwi-controlled, but we've got to start getting more equality and equity around the funds that are dispersed to us. (Mental health sector, Māori)*
Rangatiratanga of tāngata whaiora[5]	Rangatiratanga was raised in regards to individual sovereignty and that this is reflected in the validity and importance of tāngata whaiora voice. We heard that upholding tino rangatiratanga would provide a significant	*And also, to me the Mental Health Act to say, Oh, you've got to take your medication, so let's just give you your pill, but rather than helping them out helping us find our own tino rangatiratanga, helping ourselves determine our pathway, and you fit our way and, and so for me, I would like to see the clinical services, I would like to speak, I would govern what I want, and you support me how I need to do that… and if it doesn't work, I'll tell you it's not working, and you need to listen to me and say, you know… Those are the things that are going on for me, [name] when it comes to the Mental Health Act. Because*

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[5] Participants about rangatiratanga in relation to individuals. It is acknowledged that rangatiratanga is typically understood to be about collective rights (for example, tāngata whaiora in the context of their whānau, hapū and Iwi) and not in relation to an individuals rights.

	shift from the current legislation.	*I just see it as a weapon. I see it as a weapon that they use. That really, really, really, really, really upsets me. Because I've seen that happen on, you know, many of the whānau who I know, including myself… (Mental health sector, Māori)*
Whānau	We heard that whānau is a central tenet of te ao Māori and that whānau need to be included in all aspects of supporting tāngata whaiora. The Mental Health Act was heavily criticized for not placing significant weight on whānau voice.	*One of the things that I'm really keen to see in changes to the legislation is the inclusion of family whānau through every step of the journey. (Mental health sector, Māori)*
Mātauranga Māori	Provision for treatment of whaiora should include the possibility of engaging in practices that reflect te ao Māori. We heard that legislation should include provision for the equivalency of Māori cultural practices, such as tohunga and nga ringa whakahaere.	*The other part is when do we actually have our tohunga and our ngā ringa awhi and ngā ringa whakahaere. (Mental health sector, Māori)* *Whaea, I really want to take on board, what you said previously around mana enhancing practices and approaches. And also the need to have a look at Te Tiriti o Waitangi and its articles, particularly articles that pertain to act of protection and wairuatanga because these not really available - kaumātua and kuia. They're not really available, you know, things around rongoā. But I know that there's quite a significant shift to work towards that and I'm just wondering how we would apply act of protection as well as wairuatanga within the mental health. (Mental health sector, Māori)*

	Such provisions include: ▪ te ao Māori healing practices (that may occur outside of a western clinical setting) ▪ ensuring clinical environments include provision for kaumatua and tohunga	

CAPACITY AND DECISION MAKING

Introduction of a test of capacity

From Māori working in the mental health sector we did not hear whether a test of decision-making capacity should be included in mental health legislation.

Rather, on one hand, we heard some caution over including decision making capacity as a legislative requirement. In this sense caution was traced to a risk that requirements adopt a superficial and administratively burdensome process centred on the avoidance of risk.

> *What is interesting with capacity… so I've worked in a number of states in Australia. It first came in, in Tasmania, the idea around capacity and competency. What it did to the actually of the Act was elongated, so it becomes huge processes, lots of paperwork. I don't know if it was really particularly meaningful to the person, but it made the system think that they were feeling better about it, and it was around checking their mental states, so they could know who they were and, you know, date time year, Prime Minister and all those sorts of different skills. And then it's evolved as it's come through to the other states around the ability to make a sound decision for yourself, but it ends up being all about risk. So there's this person, and the end that starts like this, but it looks like from my experience, it always ends up being about risk, because there's a piece of risk to themselves or to other people - do they have a capacity to make those decisions? So in the end, it comes back to kind of what we're doing with our Mental Health Act, which is looking at risk and looking at their ability to look at themselves. So I don't know, in the long run, whether it's made a huge amount of difference to what ends up happening when the Act gets utilized. But certainly, having somebody that is struggling, and again that's a judgment that we're making on what we think we're hearing from what this person is doing. But this person's behaving like what other people are saying about them. And based on that. And now assessment or thinking about looking at this person, hearing or listening to them, we make a decision about whether we think that they've got capacity to make a decision. So it always comes down to the clinician or to the people involved, or someone looking in on this person to test their ability to make that decision. And if we think that it's not functioning, then we decide that we have to enact the Act. (Mental health sector, Māori)*

Rather than focusing on a measure of capacity, we heard from Māori working in the mental health sector a high degree of support for the inclusion of whānau in decisions surrounding the capacity of tāngata whaiora.

> *When we look at mahi tahi, and working alongside the whānau, I believe that one aspect of helping people make an informed decision, because doesn't whānau know the person better than anyone else? And then adjacent to that, if we come back a few*

> *steps, we need education on capacity connected to decision making around this process, as well. (Mental health sector, Māori)*

We heard this is essential as the inclusion of whānau challenges the current privileging of psychiatric decision making.

> *I think one thing, you know, when we're looking at who decides, say, a person's capacity, that we need to consider, you know, who has that data slice. You know, try to just be in the moment as a psychiatrist, responsible consultant, but it shouldn't just be left up to maybe him until they're wondering who else should be there or be involved in that decision of deciding whether a person has capacity or not, particularly when they are Māori. (Mental health sector, Māori)*

> *And I mainly raised us because I'm, you know, were recruiting more and more international staff and psychiatrist professionals to our services, and a lot of them have really had no clue about, you know, a Māori for cattle. And, you know, we run the risk as we always have of being misunderstood, misinterpreted. Because, particularly, you seen, you know, a lot about people use just a kupu in their sentences. And when you're talking to people, they come from another culture, they must understand what you're even saying. And that's the reason why I'm asking and raising the issue about capacity. And who makes the decisions? (Mental health sector, Māori)*

We also heard that the wellbeing of tāngata whaiora can be protected by ensuring their wishes, needs and perspectives are a central consideration. We heard that incorporating the perspectives of cultural advisors, cultural practitioners, clinicians, legal experts, significant others and independent peer advocates can afford holistic decision making around the needs of tāngata whaiora.

> *Nothing ever sits in isolation. And I'd like to see the same for this decision around capacity as well. Because nothing sits in isolation. We then have whānau, iwi, hapū who could possibly step into that space or our Māori providers. So that would be my whaakaro in terms of the space; if we didn't have other options in terms of who else could vouch for our tāngata whaiora if they are not in a safe space. (Mental health sector, Māori)*

> *There are opportunities for people to include cultural practitioners or, you know, other whānau in the mix, makes it a whole different journey for whaiora. (Mental health sector, Māori)*

SUPPORTED DECISION MAKING

We heard from Māori working in the mental health sector that in accordance with te ao Māori, that mental health legislation should explicitly state that whanau are required to part of the decision-making process.

> *When it comes to the Mental Health Act and actually bringing mana and teeth for whānau and family within that Act? Because of the very fact that capacity and decision-making hasn't been supported for whaiora the inclusion of the whanau, family voice is still at largely missing. So we have to look at the legislation in the Mental Health Act about how we can bring more mana and the whanau family voice. So the need is to actually refocus ourselves and see how we could make that change for the legislation. (Mental health sector, Māori)*

We heard that, in adherence to a collective notion of self, mental health legislation needs to reflect that decision making is a collective exercise.

> *And just giving the whānau options to is really, really important. And I totally agree. You know, it's not only about the individual, but it's also their whānau. So that they all come through that process of seeking support in a way that they're able to, you know, wrap around their whanau member, but also that they're supported as well. (Mental health sector, Māori)*

We also heard that whānau should be included "in every step of the journey", inclusive of care, treatment and support of tāngata whaiora.

> *One of the things that I'm really keen to see, and basically changes to the Mental Health Act, is the inclusion of family / whānau in every step of the journey, where, you know, a family member is mentally unwell and in services. And when I sort of say that, I guess the one thing I'm always cautious about is that the whānau are actually involved in the care and support of their, you know, service user. (Mental health sector, Māori)*

As previously discussed, we heard that mental health legislation should acknowledge the wishes of whaiora about the inclusion of whānau are paramount. We heard that this is important because it cannot be assumed that all tāngata whaiora have a positive or supported relationship with their whānau.

Ensuring family, whānau and significant others are best positioned to support tāngata whaiora

From Māori in the mental health sector we heard whānau need support and to be able to support their loved one. We heard that whānau are often confused about their loved one's mental unwellness, the nature of their loved one's distress, treatment options and what it means to be placed under the Act. Within this context, we heard that mental health legislation needs to include provision for whānau-focussed education. We also heard that such education needs to include supportive in-person encounters with mental health professionals. We heard that this was especially important in terms of whānau understanding capacity and decision making.

> *The Mental Health Act needs to be applied in an assisted manner because whānau don't understand the Mental Health Act. (Mental health sector, Māori)*

> *And also education on our capacity connected to decision making, because largely whānau don't understand the different sections within the Act which doesn't give them the ability to actually fight for their loved ones pertaining to the Mental Health Act. (Mental health sector, Māori)*

> *The Mental Health Act doesn't uplift or value whānau voice. It disempowers their inclusion, as you've articulated really well, and the decisions made in the loved ones treatment and care. So whānau voices, largely over decades have been ignored. And just wondering how we will actually bring teeth or mana within the Act for whānau whānui, because there isn't one there at the moment. (Mental health sector, Māori)*

> *You know, you said about our tāngata whaiora, but it's actually about our, it's about the whānau as well, you know. So we can't just focus on the individual, because if we're expecting our whānau to, you know, to be able to care for that tāngata whai i te ora they actually to be resourced as well. You know, we've all got that various sort of individualized focus, but our whānau also need to be resourced as well. They also need to be part of when they do the planning. That the goals and aspirations are captured as well and that their hauora and oranga is also looked after, you know, so that is part of it - is helping them to build that sort of capability and capacity to be able to care for their whānau. But they also need to be taken care of as well and they need to be resourced to do that. And at the moment that's just not happening. You know, we just again very individually focused.. anything outside of that, not really interested, but the time that tāngata whaiora is not going to be well, if the whānau is not well, right. I'm just jumping on your waka [name] around, we can't just focus on this individual we need to - we want tāngata whaiora to be well - we will check to make sure the whānau is well because they're the ones who are going to be the daily, you know, and supporting them with the things that they need. (Mental health sector, Māori)*

> *Particularly looking at educational capacity connected to and decision making. And so how we would actually support our family to make those decisions in their capacity, and also in how that would be mana enhancing in regard to the decision making process. And its whole entirety. (Mental health sector, Māori)*

RESTRICTIVE PRACTICES

Reduction or elimination of restrictive practices

From Māori in the mental health sector we heard that restrictive practices are punitive and commonly result in tāngata whaiora and their whanau being traumatised.

> *Seclusion was used as a form of punishment. When I came into mental health, they were prominent on the landscape, seclusion rooms. And when I talked to a lot of my colleagues that have been working in and out of psychiatric hospitals into the hospital, the old ones that have been around a while, could do the kōrero with a lot of our whanau. They were good at it. But those that just finished the training, and spent about*

> *five years in the institution, and then the changeover of the institution, that's when you saw how they would utilize the .. use seclusion as a means of incarcerating our whānau. And they were so punitive in the way they use those rooms. So we're doing away with seclusion. (Mental health sector, Māori)*

> *I remember in 2000 doing a review of forensic services and visiting the six main forensic units throughout the country, and I said to them, take us on a journey as to where the person would arrive and, you know, check us in like at a hotel. And I remember just being so traumatized by that experience, arriving in a caged place, and then been taken through this metal door that was about 20 inches thick. And, and just hearing it closed behind me was just devastating. And you know, I thought, goodness and a person who is distressed and well, what would this do to them? And then they put me in the room and I say, No, you're not shutting the door, because I'm claustrophobic. There's no way you're shutting the door. And, and I thought, yeah, there has to be different ways. There has to be a different way of making this okay, for people see, and so environment, I think it's very important. (Mental health sector, Māori)*

We heard from the mental health sector that acute inpatient environments can exacerbate an individual’s distress and prevent healing.

> *Nor are those environments welcoming. And why should they be called seclusion rooms, when there should be actually another room where people can retreat back to and they should be also decommissioning of, of seclusion rooms. (Mental health sector, Māori)*

> *There needs to be environmental modifications as well, because at the moment, the environments are not conducive to Māori recovery. (Mental health sector, Māori)*

We heard from Māori in the health sector that staff often lack sufficient skills to engage in de-escalation.

> *If we had staff that could read earlier when they notice somebody starting to become more distressed, and then at that point interact with either calming methods or calming them or having some space where they could calm or using medication judiciously in that situation. You wouldn't need to have seclusion. (Mental health sector, Māori)*

> *Sometimes they’re really unwell and what they want to do is do damage to people. They do do damage. You've had some significant assaults and people have left the profession because of it. Now on the other side of it, sometimes you have staff that are not skilled enough to mediate countertransference. And whatever issues are happening for them that come in sometimes come and escalate a situation. So that can happen. Sometimes a person has got some really big thing that they've got sorted out that they just need to be able to do. But now they're stuck in the situation, they've become very angry, fearful, frightened and then when you get into it and figure out what it is that needs to be done for them. That would be because sometimes it's it the*

> *cat, or the dog is at home by itself and nobody's feeding it and who's going to make sure that this animal is looked after. But they get so riled up that you can't get to it, they can't get to the issue. And so having the ability to put them in a quiet space, calm, means that then you can then address what is going on for that person. (Mental health sector, Māori)*

We also heard that restrictive practices damage the relationship between tāngata whaiora and mental health staff. We additionally heard that restrictive practices are often unnecessary in inpatient settings. The unnecessary nature of restrictive practices was evidenced in the effectiveness of kaupapa Māori services responding to the needs of tāngata whaiora.

> *I remember, at one phase in my kaupapa Māori mental health career, we said that we weren't going to be involved in seclusion or restraint or any form of restrictive practice, because it would damage the relationship that we would have with the individual. And that we wanted to be there to honor the person and acknowledge them, or welcome them as much as we could in the first instance. But if we had anything to do with seclusion or restraint or restriction, that that had an immediate impact on the ability for it to damage the relationship that we could form. So certainly, we did that. But at times, and I remember on one occasion, when one of our kaumātua walked into the room where a person was about to be restrained. It just immediately changed the whole dynamic. So, you know, the presence of those kaupapa services, I'm thinking of you, [name], in your kōrero, can make a significant difference. (Mental health sector, Māori)*

We also heard of multiple examples where zero seclusion practices have operated successfully in Aotearoa New Zealand. Examples were shared to reinforce the need for mental health legislation to explicitly exclude seclusion as a practice and instead placing emphasis on the use of de-escalation and modifications to the environment.

> *So as you know, [in-patient unit] has done away with its seclusion rooms, so it's probably one of the first DHBs to actually do that. They've been seclusion free for about close to two years now since I've been here. … there was a big process that went into place before we could actually close those rooms off, and then say that they were not going to be doing that anymore. So what we did was skill the teams up or the workers or the kaimahi up into doing that kōrerorero. And recognize the signs of our whānau of riri and aggression a while beforehand so we don't have to seclude whānau. (Mental health sector, Māori)*

> *We now have five DHBs that have zero seclusion, and that actually haven't had it for probably two or three years. So that's, that's a big turnaround from what it was. (Mental health sector, Māori)*

> *[DHB] has zero seclusion, and it hasn’t had seclusion for a long time now as because they've made massive modifications to the rebuild of a unit that are more conducive to modern recovery. (Mental health sector, Māori)*

Mātauranga Māori

Rather than restrictive practices, we heard health care should be designed in alignment beliefs and practices embedded within mātauranga Māori.

We heard that if tāngata whaiora receive preventative support and intervention there will not be a need for restrictive practices. We heard that Aotearoa New Zealand's current use of such practices is a reflection of a lack of comprehensive and preventative health care. We heard that practices reflective of mātauranga Māori would rely on cultivating preventative relationships between community-embedded services, tāngata whaiora and their whānau.

> *One of them is by Māori for Māori. If it's an Iwi provider they would know every whānau in their rohe, and they are able to make those connections and make those conversations happen for our whānau. So for me, it's about ensuring that that Māori are involved like you say at the at the front end, but I think it's also what I said at the beginning of my kōrero that we recognize in the education or give some sort of guidance to our whānau. What are those early warning signs whānau? What are the things like drink? What does drink and other drugs cause that may affect the way our whānau behave? (Mental health sector, Māori)*

> *So what work has been done on the community? Private people come into secondary services, because let's face it, not everyone should be coming to secondary services. And we should be doing what we can to maintain one's recovery around the community. (Mental health sector, Māori)*

In terms of acute mental health care facilities, we heard that kaupapa Māori approaches would enhance an individual's mana and assist with their healing.

We heard that appropriate engagement with tāngata whaiora and whānau is essential to a model of care reflective of mātauranga Māori. We heard appropriate engagement practices are vital and guidelines should be included in the new legislation.

> *The pōwhiri process is [extremely important]. When we don't get DAO processes right from the start there is a domino effect and it can actually heightened aggression or even perceived violence. So I think high time that we build it into the guidelines. (Mental health sector, Māori)*

> *People don't know how to engage with our whānau, you know? More needs to be put into making sure that people understand how to engage with whānau, so they can actually get great outcomes, I'll find, yes, they know, if you're not used to engaging with them, they may seem intimidating. But actually, if you have the right person there and I've seen this done with, you know, whānau, but obviously, I can't talk about who that was, was in the state of distress, we had one of our kaimahi who do a karakia. Gone, you know. Just those sorts of things, but unless you know how to engage with the whānau one to one, you know, know how to respond in a way that's going to get them to a place of tau, you know, we're just wasting our time. And I just feel that, you*

> *know, at the moment that people who are engaging with whānau and doing it in quite the right way. You know, so did this one thing. But the thing is, we've been talking about workforce development stuff for, like, 10 million years. (Mental health sector, Māori)*

> *I think that initial contact makes all the difference for the rest of the journey, and then feeling respected and being able to reach out for help, as they move through. (Mental health sector, Māori)*

> *It's really important to actually see the person and really make that time to connect, you know, not say all the proverbial, you know, diarrhoea that some people, you know, write in the notes. But it's to actually see the person you know, cos our whānau know they can see through the crap. You know, they know if you're being pono… (Mental health sector, Māori)*

> *One of the things that I would talk through with whānau is I'd flip the Act on its head and whakamana our whānau and, the family the wider whānau, because I'd say to them, you know, here's this piece of legislation, but it's about what we can do to awhi and support you as a whānau, your taonga, through this pathway, and it's really about making us work for you, not the other way around. So I really think we need a whakamana our whānau our tāngata whaiora there on the journey. And it's about us actually working for and supporting them, and ensuring that they get the effect or, you know, whatever it is to be wrapped around them to make the process safe for them. Rather than them feeling done to. (Mental health sector, Māori)*

> *The process often feels quite rushed, and the need for ensuring that whānau and cultural expertise, sometimes it's being missed, and actually may change a whole lot of outcomes and a whole lot of experiences, and actually may create further mistrust and trauma. So I think there's, you know, been very clear, korero or about how do we look at stopping and slowing down some of that to make sure that whānau and anyway, or whoever the cultural support can be put in place to understand what's really going on. For this person in the photo that was very clearly being heard from some of our other sessions. So just want to touch on some of the conversations that I've had. And while Section 5 is there, it's kind of sometimes nice to have rather than a need to have, which I think can be some of the challenge and why maybe some of the issues have been created, because it's not part of what needs to happen. (Mental health sector, Māori)*

We heard of the need for mental health legislation to make provision for traditional healing practices.

> *Take them down to the river and give them a few dunks there. That'd be great to nail down, you know, just using your environment. (Mental health sector, Māori)*

> *I think if we had the hospitals that we used to have, we had big open spaces where somebody, if they're feeling really agitated, could go and just have some space, get*

> *away for anyone in a place where they couldn't harm themselves or harm anyone else, we would have a different system. (Mental health sector, Māori)*
>
> *The other home we've had has been talking about outside space and retreat, places and spaces that are more of healing, rather than of containing. (Mental health sector, Māori)*

We heard that the acute mental health environments could be better designed to incorporate aspects of te ao Māori.

> *I visited one of the units in Auckland, and they had this huge pou in the center of the unit. And I often saw the whaiora go up and touch parts of this pou. And and you could see that they were connecting to they obviously had learned of what the pou story was. And there were many stories woven into this pou. And I could only just imagine what our support of that whaiora, by simply being there was supporting how it was supporting these individuals. (Mental health sector, Māori)*

Māori working in the mental health sector reported that restrictive practices are not necessary when the mana of tāngata whaiora are central to service provision, when tāngata whaiora are appropriately engaged. We further heard that mana enhancing practices centre on staff relying on de-escalation practices, as opposed to a reliance on restrictive practices.

> *Around restraint, whatever that restraint looks like, we're really working harder to [in-patient unit] to do away with that. So really trying hard to do that. The art of communicating with our whānau, taking them for hikoi, giving them access to telephones or to make phone calls to their whānau. But also knowing how to talk to our whānau, when they get riri. (Mental health sector, Māori)*
>
> *I guess asserting ourselves as Māori, aye koka, in terms of not coming in with eight or 10 staff rushing in. Because I make them stand at the door. And I'll go in there with just one another, and trying to maintain the dignity and mana. Unless you understand the drivers of the behaviour and why they become with this heightened aggression, with these people perceived it as violence. And then as well, that really cuts back on these clinicians that have just come out of school where it becomes quite risk adverse. But I know that your DHB has been doing really well. With all what you've been alluding to. (Mental health sector, Māori)*
>
> *We need to constantly remind ourselves that, you know, here we have a tāngata who has mana, and it's constantly reminding he tāngata tenei. He has a role in his whānau and he is a little unwell today, and we need to remind ourselves, that's who he is. He's a father, he's a brother, he is a son, he is also the caregiver of his whānau. And if we keep that in mind, that we have to respect that person for all the hard work that he's done for his whanau before becoming unwell. It's all it is, you and I just look after those symptoms of the fella, but he is the tāngata, he is the man, he is the man of his house. And if we remember that, and if you want to go even further, then we look at his whakapapa, Ko wai au? Where did you come from? Where is your whānau? Who is*

> *your tīpuna. And lo and behold, he's probably connected to you. And you can do the whakapapa to him. (Mental health sector, Māori)*

We also heard from Māori working in the mental health sector that legislation should require organisations to engage in follow up processes with tāngata whaiora who have experienced restrictive practices. The spirit underlying this would be to assist tāngata whaiora to address possible trauma arising from enlisting restrictive practices and to develop a strategy to avoid enlisting such practices in the future.

> *Within that, if we look at restorative practice, it's not about restraint, seclusion. It's actually repairing the conflict between the clinician and the whaiora. That's what I'm talking about. (Mental health sector, Māori)*

Acute mental distress and substance use

Māori working within the mental health sector described a degree of uncertainty in regard to the use of restrictive practices for those experiencing substance-related unwellness, namely they were unsure of how to minimise trauma while affording the individual protections.

> *When our whanau are drug affected, and in particular with some of the drugs that are coming through at the moment, with the mixing the meds, or the whole palette of other stuff. There's nobody home. The end. They're very aggressive, very violent, very abusive of staff. It's not safe for anybody and the police bring them to us and you'd think that the police would hold on to some of these people because it's so violent, but they typically drop them at the door and standing in the room or to, you know, a woman, maybe older maybe small and then they drop off this huge, so big person, powerful man to be here. To get security, the police to come and help. To get to a situation, calm this person down and utilize medication accordingly or seclusion. Sometimes seclusion is enough, they don't need meds. If you don't have seclusion, then you're utilizing medication. And sometimes people that require medication that may be if you had seclusion, what not to utilize and sometimes you're using huge amounts of medication to bring someone down. Whereas if you had a space that they could go to … summing up what used to happen on some of these bigger hospitals. Now unfortunately, we threw the water out with the baby when we got rid of those institutions, we got rid of some really amazing spaces that people had that they could go and open spaces fresh air. Now we have this lockup thing with these unpleasant not even a good, it's just another space outside. That means you get fresh air, but it's not very pleasant in the space itself. Isn't particularly pleasant, but that's what we have. (Mental health sector, Māori)*

PROTECTING SOMEONE'S RIGHTS

We heard considerable scepticism from Māori working in the mental health sector about the way in which past legislation has made superficial reference to the Treaty of Waitangi. We heard concern that references to the Treaty have been made with little or no attempt to hold those who work under the legislation accountable. We heard, therefore, that new mental health legislation that makes reference to Te Tiriti must include mechanisms to monitor the enactment of the legislation.

> *And that's why I challenge, I know that it's lovely to have the Tiriti. I've seen you know, we've seen it [facilitator name] aye. For years we've been in the government, I've seen that they use the Tiriti. "Oh yes, use the Treaty," while they shake the dust off the shelves, you know, and bring it out for a little while and go "Oh yeah, we're doing the Treaty, let's put it back in." And so for me, some of the kōrero around the Treaty is a backdoor for Pākehā to walk away from that, gives them a backdoor way out of things. So for me, you know, for me, if we're going to do the Treaty, then I want there to be consequences. If you don't follow the Treaty properly, then there needs to be consequences. And also "You need to do…" go into Te Tiriti. Well, it's got to be more than words. (Mental health sector, Māori)*

Centrality of whanau

We heard from Māori working in the mental health sector that whānau are pivotal to supporting tāngata whaiora and we heard that mental health legislation needs to explicitly state that whānau need to be included in the decisions about compulsion, care, treatment and support of tāngata whaiora. In this regard we heard that the rights of whānau to be included need to be embedded in mental health legislation.

> *You also raise another point about family and I just had a quick scan through the Act and Section 5. There's only one phrase that talks about the recognition, importance and significance to the person of the person's ties with his or her family, or whānau or hapū. Now, it's there, but how often is it upheld? And who upholds it? You know, I know certainly the journeys that I've had when the Act first came out back in the early 90s. It was all about the individual. And if there was any family member that was there, then hey, "Can you just go and wait over there? And we'll get back to you shortly." And just yeah, the very no- acknowledgement of family at all. (Mental health sector, Māori)*

Ensuring tāngata whaiora and their significant others are informed and fully understand impacts around the mental health legislation

We heard about a high degree of confusion amongst whānau when their tāngata whaiora are placed under the Act. We also heard Māori working in mental health that many whānau do not know what their rights are. As a consequence, we heard many accounts of whānau feeling confused, powerless and traumatised. We heard that whānau have the right to be fully informed and that this right, and stipulated processes of communicating those rights, should be included in new mental legislation.

We equally heard that acknowledging the centrality of whānau requires provision for culturally appropriate engagement practices, education regarding mental health and mental health legislation to ensure that tāngata whaiora and whānau are informed and equipped to make supported decisions.

> *I guess for me, everything starts at the front door. The whanau’s experience of what they are informed of, how they access awhi and tautoko, if they are a whānau known to the system, and or any sort of touch point or entry point into the system. Because a lot of whānau aren’t informed or educated or equipped with the relevant information. So for me, that's really, really important. Language is really important as well, because a lot of the times the language that whānau come across, you know, they're all really excluded and are made to feel like a bit of a hoha, you know, and it's quite a challenging process to even think about, you know, walking that journey with a loved one. So it can be quite intimidating, scary, and a journey of mamae for them. So I think language is really important and just being informed, you know, as to where to go and access the support. I definitely think like [name] talked about, it's definitely about the approach. It's about the whanaungatanga. It's about the timing, space and place of where things occur because You know, having walked through and being part as a DAO, you can have very, very different outcomes based on who's the person making those connections and who's around. (Mental health sector, Māori)*

We also heard that the wellbeing of tāngata whaiora can be protected by ensuring their wishes, needs and perspectives are a central consideration. We heard that incorporating the perspectives of cultural advisors, cultural practitioners, clinicians, legal experts, significant others and independent peer advocates can afford tāngata whaiora one level of protection. We also heard that this protection should be included in new mental health legislation and that inclusion of these significant others and cultural support should be clearly stipulated in new mental health legislation.

> *We need to ensure tāngata whaiora and whānau are in the discussion around having access to Iwi, whakapapa, kaupapa workers who can support the person at the time of need. (Mental health sector, Māori)*

Workforce and accountability

From Māori working in the mental health sector we heard repeated concern about the inherent biases of mental health professionals that have disproportionately disadvantaged through use of the Mental Health Act. We heard that the disproportionate representation of Māori being placed under the Mental Health Act has occurred as a result of racism and discrimination. We heard racism and discrimination manifest in a disproportionate readiness to place Māori under the Mental Health Act and well as Māori being placed under the Act for longer periods of time than non-Māori.

We heard that the mental health workforce holds a pivotal role in relationship to the wellbeing of tāngata whaiora. We further heard that mental health legislation needs to embed requirements for the mental health workforce to demonstrate cultural competency as a prerequisite for working with Māori. Moreover, we heard that mental health legislation needs to include mechanisms of monitoring workforce performance and accountability in the event that practitioners fail to adhere to a defined standard. Notably, we heard that the role of district inspectors is not appropriate in this arena because of a lack of perceived independence from the system itself.

> *The people that come in contact with our people at any juncture, actually, whether or not it's the beginning of or trying to find some help and wanting to ask some questions. That workforce is just so incredibly important. There's a lot of a need for a systems approach. So while we're looking specifically at the Act, we have to have a way that we can monitor that actually, this is working properly for our people. (Mental health sector, Māori)*
>
> *Actually our workforce, largely remains unaccountable for a number of things. So I don't know, like, I hear you talking about the systems. And that's where it happens. But not enough of the Act or legislation talks about what is the expected or the minimum bar of what it is that we're expecting. We have all the beautiful documents but what we don't have is accountability. There needs to be some kind of measure of accountability, back to those receiving services and those people that are around them, their whānau and their support mechanism. So I don't know how that happens. But it's kind of like the thing that comes through all the time and slaps us in the face. (Mental health sector, Māori)*
>
> *I like what [name] said before, around accountability, like, I think this, you know, there's other stats that we can pull and be accountable, you know, from a long term point of view. Like, you know, KPIs on us add on, you know, all those things, but, you know, immediately and at that moment of time for people in distress, I think, you know, practices in which you know. That's what I know that a few services here in [location] are looking at implementing. If not implementing at the moment. (Mental health sector, Māori)*
>
> *Certainly many of the things that we've discussed throughout the morning touch on some of this to know enabling throughout the entire journey, that an individual may travel in regard the Act, that there's those checks and balances around the whānau being involved, and ensuring that the mental health service system has the right support mechanisms to be able to support people. You know, I remember back in the day, we used to check all the time how things went. If there was a crisis call out, and how did it go. And, you know, often the multidisciplinary team will share this worked really well, or that it was really tragic. They just don't seem to happen as much anymore. (Mental health sector, Māori)*
>
> *It'd be wonderful to nurture staff that imbue kindness. But how do we measure that and actually monitor? Monitor it to make it happen. (Mental health sector, Māori)*

An independent review body

From Māori working in the mental health sector we heard a great deal of support for the creation of an independent review body with a specific focus on the human rights of tāngata whaiora and their whānau.

> *In terms of the current Act that we have, that all the levers are there. But I think what we really need to do is we need to understand, you know, we do all this mahi, you know, we've got this Mental Health Commission, and all these sorts of different things are supposed to be there to kind of improve, you know, these outcomes or to improve service delivery, but it's not happening. You know, again, it's not just here, but it happens across, you know, all of health, you know, all of our Ministries. (Mental health sector, Māori)*

We heard Māori working in the mental health sector that there is a need for an independent body because experience has shown that internally reviewed complaints are not free from organisational or professional bias.

We first heard from Māori working in the mental health sector that mental health legislation needs to include provision for the independent reporting and monitoring of infractions of an individual's rights. We also heard that an investigation needs to occur immediately or as close as possible to a report being received and that an intervention should occur when an individual's rights have been infringed upon.

> *It's that feedback-informed treatment, style of monitoring. And, you know, obviously, for the quality of service for the, you know, in the first instance, for the quality of service for people in distress. But also, I guess, you know, for our clinicians and professionals, you know, to get immediate feedback to try and change their behaviour. And, you know, and that and to realize that, you know, one size doesn't fit all that, you know, you might have to continually change and nobody walks through your door, solid, you know, ways of being, but, you know, if we move towards a system that encourages good quality feedback, and sometimes it might be hard to hear. I, think we, as people in the mental health and addictions, space have to be always open to change and critical feedback. Yeah. You can read it. (Mental health sector, Māori)*

Second, we heard that an independent review body should exist to review compulsory decisions, complaints, treatment orders, appeals against being under the Act or extension of an order.

We heard that such independent review bodies should replace the current role of the courts and the creation of an independent review body should be clearly articulated in the new mental health legislation.

APPENDIX 4: GENERAL MENTAL HEALTH SECTOR

CONTEXT

We heard from the mental health sector that there is a need for the Mental Health Act to be made more relevant and to be more client focused. We also heard, however, that there are a number of complicated issues.

Participants related that the Mental Health Act is sufficiently ambiguous to result in varied and inconsistent application. Differing interpretations and applications of the Act is evidenced in differing application by DHB and ethnic groups. As a consequence, we heard that new legislation needs to ensure consistent application

> *I had a conversation with the team actually, before I come through. And one of the feedback that they said was that the Act that we've got now can be quite ambiguous and open to a lot of interpretations. So having a new Act that is probably less open to interpretation would be helpful. (Mental health sector)*

> *And one of the things I'm really interested in is there is about how we, we make sure that there is consistency and people get the right sort of training. So whatever comes out of this, we made sure that when doctors and other professionals come to the country, they're able to, to use the Act and the spirit with which this this this this provision is meant because I think that can be a problem. (Mental health sector)*

We heard that the Mental Health Act has been misused. Rather than appropriately engaging with whaiora, the Act has been used coercively to force the individual to receive treatment and then at times used with positive intent but against the principles of the actual legislation.

> *One of the things I always kind of think about really is how, how do we make mental health teams engaged with, you know, the service users and whaiora in a way that doesn't require the Mental Health Act, you know, so I think sometimes, you know, having previously I spent a long time working in courts, and sometimes I think the mental health in a rather perverse way, the mental health end gets used to make the teams or the services, engage with the with service users. There's something wrong with that really. So I guess what I often kind of think about is how do we actually make people engage with their clients without having to use compulsion? (Duly Authorised Officer)*

Participants stressed that the Mental Health Act should be used as a last resort only and other alternatives to the Act should be tried first. Further, we heard that such efforts need to be documented and the need for such documentation should be embedded in legislation.

> *I just say I agree with that point. So I think, you know, the Mental Health Act should always be the last resort. And I think even if we make changes, there's the risk that it will still be used incorrectly and probably when another alternative is good to use. So I don't know what kind of checks and balances we can put in place or further education*

> *to try and find a different way of doing things or exhausting all other avenues before going down that route. But worth considering, (Duly Authorised Officer)*

There was suggestion that the Act is focused on detention rather than treatment and there needs to be more focus on holistic and person-centred treatment and in- and out-of-inpatient services so the individual can return home sooner. Within this context we also heard that the provision of ongoing support is essential.

> *At the moment, there's nothing built into the law to require us to do anything but detain people. We don't have a say anywhere in this, that we're going to do anything but detain people, it doesn't really matter how you define that. It is not holistic. We just justify that the grounds are met, then we detain somebody. We don't actually have any responsibility for saying what we're going to do after we detain them. I can see how that's frustrating for people, "So you detain me, but I have no way of holding you to account what you're going to do when you detain me and whether that's going to make any difference". And you can continue to do that for years on end. And so I think… if we think about it that way, I mean, it actually helps us to think about the kinds of things that we might build into the actual legislation itself. It gives us some sense, then of what of the context of how that process should be enacted, of who should be making the decisions of how the process should be enacted. You know, whether it's a family group conference or if it's, you know, some therapeutic jurisprudential process. And then it also gives you some sense of actually what, you know what the. So what is the contract, this is a contract, in return for taking away your individual freedoms, we must make a contract to provide some stuff that justifies us doing that. And at the moment, we don't have to do that. And I think that's wrong. I think that if we would have turned that around to a to a proper, you know, if you went if you if you took a civil case in any other jurisdiction, that's about us coming to an agreement about what the outcomes going to be. And at the moment, I don't think… that I don't think patients or families have any role in that at all, actually, and I think that's wrong. I think we should have to make some commitment, or what we're going to do. And sure, sometimes that doesn't work. Sometimes it cant happen, but at least we make a commitment for what we're going to do. It then becomes a proper process of accountability (Psychiatrist)*

> *We talk about easy in and easy out to services. One of the biggest challenges with the current ability to use the Mental Health Act is it is incredible cumbersome, to get people onto the Act, even at first point of assessment. We need to make it easier while maintaining rights, Much shorter timeframes and no longer having long-term treatment orders so we can support people quickly. (Clinician)*

> *It would be short-term for an acute phase and then there would be a transition to informal status – while clinical risk is there for the safety of the tāngata whaiora and others, that would be the requirement – as they start to become well they should be reviewed and discontinued. (Clinician)*

Participants stated that a shift to a holistic and person-centred paradigm might be achieved by incorporating Approved Social Workers, similar to the model operating in the United Kingdom or an independent person to facilitate the process. We heard that the incorporation of a similar approach may reduce the enactment of compulsory orders in lieu of alternative treatment and support pathways.

> *The other only other thing that I've been thinking a lot about lately, particularly, is I know, in the UK, the DAOs were specifically social workers, and it was all around having that holistic picture, but also being able to kind of same kind of almost stop the Mental Health Act process and say no, there's a different route, we could go here. (Mental health sector)*

> *I was just thinking a solution could be having an independent role outside of the DAO. The DAO role is obviously an independent role. But actually, you're almost always the clinician completing the crisis assessment on that person. And then when it becomes evident in the Mental Health Act is needed you become a DAO and so you kind of almost always have two hats on really, It's kind of like the rights at the point of Section nine are one thing, and I agree with the idea that they kind of need to be revisited and more. In my view it kind of more aligns with the district inspector role than it does the DAO role really, but it might not, but also might not be quite at that level. So someone kind of completely independent, like, almost equivalent to that sort of duty solicitor role that they have in courts, for people that are in court. You know, just somebody that could speak to people outside of a crisis later on and revisit things. Someone that's not one of the nurses that's looking after them or not associated with the awful psychiatrist that keeps them under the Mental Health Act or whatever. (Mental health sector)*

Participants stated there is a need for a paradigm shift. We heard that the current approach to acute mental health is risk aversion and such clinical attitudes act as a barrier to the mental health workforce listening to the needs and wishes of tāngata whaiora and providing treatment and support.

> *Need to move away from such a paternalistic Act. But it is difficult as there are times where you know the only thing you can do is step in. Sometimes we get to the point that we are doing things that are causing harm because it's hard to take risks. We need to get to a point where we can take some risks – stronger peer and culture inclusion (Clinician)*

> *I've always felt, in fact, since the 80s, on the first conversations around this this current Act, that the interpretation defaulted to risk and safety when in actual fact that had to do with treatment and support. And I believe that we have that the pendulum swung too far toward a kind of medical legal definition and too far toward the need for severity of risk to be evident, because that became the threshold didn't it? (Duly Authorised Officer)*

While complicated, DAOs agreed that there should be a greater focus supporting people in their homes and in the community and that this should be directed under any new legislation. It was suggested that such home and community-based care, with the support of their whānau and being in their own environment, may assist people recover faster.

> *They're working with people in their own homes, in the in the communities pulling people the expertise out of inpatient units and putting it into the community. Managing people at home, definitely, it's definitely better for person if we can kept them at home and with their family. So that would be better than trying to put them into a mental health unit, for sure. And especially like our mental health units are all locked. So we've got like, even if they're in an open Ward they are within a locked, open Ward, so they'll go in voluntarily, but still be locked. So having them at home with support, but again, you know, everyone's quite short staffed in the resources to be able to provide the care that they probably need, as they are really unwell. And this is going to be problematic. (Duly Authorised Officer)*

Further, participants acknowledged that a lack of resources and often wide geographical catchment areas can act as a significant barrier to whānau involvement.

> *I think the other, you know, there are a few DHBs where the geographical kind of sparseness of it makes it very, very difficult. (Mental health sector)*
>
> *I keep talking about when I was looking at Lakes, you know, we've picked someone up from Turangi and we transport them back through Rotorua. And, but I don't the whānau have the financial ability, often I didn't have the resources to come through, and we can't transport them either. And police are unwilling to help. And so to be able to kind of get some of that stuff done was really, really hard. So yeah, I think we also need to think about those locations where it's kind of really tough to make that. (Duly Authorised Officer)*

While audio-visual links provide a potential vehicle to maintain regular contact with whānau, whānau ability to access technology was also appreciated.

> *Whānau iPhone to iPhone kei te pai we FaceTime people, iPhone to Android, can't do that. Do they need to download zoom? Do they have an email address to download zoom, and some of them don't? And they had to sort that out? Because actually, we assume that people have the ability to do that. But that's not always the case. And when you're talking about areas, you know, Ruatoria have that kind of good internet access to make that possible. So yeah, I think those kind of things need to be taken into consideration. Because to be frank, like the people that are in those areas are high risk, they are coming to us much, much later. And the act is almost always needed in most situations. But the people that were actually known to do what we should be doing with so. Duly Authorized Officer)*

SYSTEM AND SERICE FRAMEWORK

From the mental health sector, a number of recommendations were made to changes in the mental health system that would significantly reduce rates of compulsion. We heard, especially from clinicians, that several of these recommendations need to be clearly stated in any new mental health legislation. It was also noted that such clarity would remove confusion and support the provision of required services.

Sufficient resourcing and coordination to enable tāngata whaiora to receive comprehensive services. The provision of early engagement with comprehensive services would reduce the risk of escalating illness that might result in the individual coming under the Act.

> *I think one of the things that would be fundamental to any, like big reduction in any compulsory component would be that the mental health services that exist within the, the DHB levels would need to be quite different in terms of how they're resourced on on the focus on those because, you know, the, you can't you can't move one without moving the other. And I think that's one of the things that I think needs to be acknowledged is that, you know, and services like internationally like I always think of Norway as example of Sweden, places like that, to have minimalist to no mental health compulsion, but their mental health services are extremely comprehensive. And I think that's the catch that allows people to have more freedom, in terms of that lack of compulsion is that they are getting treatment in a much more comprehensive fashion. (Mental health sector)*

Increased Māori mental health workforce who have the ability to provide support in accordance with te ao Māori healing practices.

> *I just gonna say, following on from that there's this whole workforce has to be put into it. So we need more, you know, Māori psychiatrists, psychologists, counselors, there really has to be put if it has to be put into that really, the capacity building so that, you know, the power imbalance is shifting again. (Mental health sector)*

Appropriately designed inpatient environments – low sensory and quiet environments would greatly reduce the need for seclusion and restraint.

> *I have worked in acute inpatient units and my time as a nurse, and it's hard to get away from the necessity of it sometimes to protect both the staff and also the person from self-injury. I think as, as was just mentioned earlier there, I think, an order further to be a reduction in the use of restrictive practices within the legislation of the Mental Health Act, there needs to be that's only one side of the coin, I think, like the environment that people who are an inpatient settings need to change quite drastically if we're going to take that approach. Because I think that the environment is not conducive to a low restrictive practices, it's quite confining, it's quite small in terms of space, it's not generally a very pleasant place to protect. There are some very nice units, but there are some not so nice units, that I think, you know, it's the basically a*

> *tandem approach to this, if they know, the better the environment the person is in and the more low stimulus areas as opposed to restrictive areas, then I think that would work. But I think just to bring in legislation that calls for it without necessarily looking at the the environment, the person's end is only going to get us halfway or make things just on manageable in terms of trying to achieve something that can be achieved in a space. (Mental health sector)*

> *We in from, from my neurodiversity sort of experience of family and people people's experiences, is that often the situation comes about of the meltdown or behaviour after a huge amount of sensory overload or things that are unpredictable, so that the situation has actually been created by everybody else. So anyhow, I just think there's a lot of work to be done on what happens before the situation gets to the stage, and I don't I think seclusion and restraint can be very, very, very short term and very unusual, personally. (Mental health sector)*

Staff need to adhere to person-centred approaches and engage in de-escalation – staff trained in de-escalation would greatly reduce the need for seclusion and restraint.

> *I suppose one of things I suppose I want to acknowledge as well as a lot of times what I would find in the for the current legislation. And the reason that is the framework to look at what's different. And I'm sure people in this room will probably have relate to this, I think, is that the Mental Health Act, in my experience, for the clinician's delivering it is done under quite a stressful environment. It's done with minimal resource to achieve the goal. And usually time is the most pressing factor. And that's, that's wrong. But it is a reality that we're faced with, you know, what we're trying to achieve a goal with minimal resources, and a timeframe that's safe, and that mitigates risk. And I think one of the things that I think, look, I'm, I believe that look, I don't mean having on here, but I do think that that legislation really needs to take into account the resource required to do something well, to do something like that's person-centred, because the reality is, what we're doing is, can be quite transactional at this moment in time. Because what we're trying, we've got three staff available for four hours to try and get this done. You know what I mean? That's not the spirit of other Mental Health Act, but it is a reality of how we operate within it. I suppose I just want to know is that is that you know, any mechanism that we look at, and I use Ireland example, because an artist what they did was when they changed the Mental Health Act, they created a division within the COC within the Mental Health Directorate that supported the Mental Health Act being achieved in a way that was more humane, more person-centred, was called the assisted admissions service. And that was a different way of looking at how the time element became less of a factor. I just think if we move into our something that's more comprehensive and supportive of the person, then we need to look at what does that look like in a transactional real world? situation? (Mental health sector)*

> *Yeah, I agree, this is a really tricky space, because I don't think the the system or the workforce is quite ready for this. I think we need a really highly skilled workforce. And I*

> *in fact, I, I think no matter how much training you have, some people still don't have the ability to manage this situation. And you need people on the ground that that do. And I've, I've seen the right people go into a situation and d be able to deescalate a situation really quickly. So I think that you know, that basic treating people with respect and you and using people who know how to do that. So it's really important that the show around the time, you know, really busy environment, the situation that has been created or the circumstances of getting a person into the seclusion areas or the service. That sort of hypersensitive is a lot going on. And so the environment needs to remove people from a waiting room area, get them connected very quickly to the right person, whoever that is, but not everybody can do this. And I think more investment in kaiawhina, or, you know, all the people that know how to deal with people is extremely important. (Mental health sector)*

We heard that restrictive practices would be greatly reduced through increase in cultural and peer support mechanisms, such as kaumātua and peer support workers. Also having cultural and peers as part of crisis services may lead to more person-centred outcomes.

> *When kaimahi and kaiawhina are around we've seen seclusion and restriction go down (Mental health sector)*

SHOULD THERE BY COMPULSION?

We heard often competing perspectives from those in the mental health sector. The one area of commonality, however, is that new legislation should include the potentiality of compulsion but only as a last resort.

> *And it's in no way a replacement for good clinical care, working engagement. Looking at people's preferences for treatment and involving their whānau. So I don't think are mutually exclusive at all, is (Mental health sector)*

Notably, no consensus was communicated over how "last resort" might be defined. At best, last resort was used in reference to a broad range of situations, ranging from acute psychotic episodes to those with severe eating disorders.

> *We have a lot of clients who have eating disorders, and we have to use the Mental Health Act quite a lot for them. Right, 7.4, wouldn't be enough. And it wouldn't provide the legal framework or the scaffolding to protect both their safety and to protect our safety as clinicians as well. So for them, I think that would definitely be something to look at. (Duly Authorised Officer)*

We heard that the potentiality of compulsion rests on occasions when a small sector of the population may require such intervention.

> *I think for the most part, you know, this is a small group of people. You know, you require this type of treatment, compared to you know, lots and lots of people who are under our services. (Mental health sector)*

> *so long as people are going to have mental illness, and they're going to lack capacity, or maybe lack their understanding that things won't change unless they accept treatment, always, in some shape or form, need that compulsory treatment, I think. (Duly Authorised Officer)*

Those in favour of drastic reductions in compulsion

Those in the mental health sector advocating for significant reductions in compulsion stressed the need to shift the compulsory focus of the Act to universal engagement, treatment and support of those living with a mental illness. We heard that Mental Health Act should be broadened to ensure that legislation provides clinical and pharmacological support for all those who are living with a mental illness. Such provision would assist people access support earlier and greatly reduce the compulsory treatment embedded within the current legislation.

> *But also, I mean, I was just thinking that you want us to bring experiences from elsewhere. So I'm just going to put something out there. But in the UK, once you've been under Section three, which is a six month order, there are some things that you maintain in terms of your rights for treatment going forward. So, you know, things like being able to access certain supported accommodation, and not having to pay for that, you know, being able to access medications, that sort of thing. And so we might want to think about, you know, what are the things that would make it for somebody who has been sick enough to need to be under the Act, what do we do to make it possible for them to keep well, and I think being able to make it possible for them to access many medications, other treatments, and, you know, GP level care, will be some really important things that we could do for this fairly, very sort of stigmatized and, you know, often quite disabled group. (Mental health sector)*

We also heard that the broadening of the Act to provide clinical and pharmacological support outside of acute times would empower whaiora. We heard that this is essential as some whaiora ask to remain under the Act because of their inability to fund their much-needed medication.

Participants described that being placed under the Mental Health Act was the first time that some people were able to receive support and treatment, as barriers to service engagement had resulted in drastic elevation of their presenting issues.

> *But actually, I think it's just we need to improve the work that we do. Anyway, so people don't necessarily end up under the act. (Duly Authorised Officer)*

> *Yes, I suppose for me, what I would say is maybe a little bit left field. But we, in my experience, I've often seen people who are on a trajectory to unwellness, that would require the current legislation to be used. And you know, it's going that way. But you know, what, they haven't quite met the the mark as yet. So there's a gray area, that's a risky gray area. For me, if I was looking at compulsion, I would try to look at it and viewed an earlier stage of their deterioration, so that it could be used much shorter.*

> *Because you know, the longer the treat that illness is on treated, the longer it takes it to come back. And you know, the more reputational damage is done to the individuals within their final and community and even whatnot. So for me, I think it's about earlier, less restrictive, more proactive, if there was a compulsion, that compulsive element. That's what I would try and see that space. (Mental health sector)*
>
> *I also think it would help us possibly with if we could just get into that fame of doing it, whether it's under compulsion or not, you could get into people actually specifying wanting to be under the I wanted to be treated earlier, because I think you touched on that Martin A little while ago, but how we, we leave things to the very last minute all the time. So we wait to someone's really, really very unwell and going to take quite some time to get better. And some people do actually, or may, you know, be prepared to look at something a little bit sooner, you know, not waiting for the whole thing to play out. (Mental health sector)*

Within this context, we heard that the provision of appropriate supports, clinical, social and cultural interventions, would greatly reduce the need for compulsion.

> *If we had systems to support, then surely we can actually do away with some of the compulsion that we do now? We know, there are certainly examples of practice and some DHBs, are taking a different approach that is actually reducing the need for compulsory treatment. So when it comes to compulsory treatment, we should be in a position of saying, "Is this absolutely necessary? Have we exhausted all other opportunities?" Clinicians and certainly tāngata whaiora will say, if you couldn't, can put a support network around people, then then you don't need necessarily to, to utilize the act, because the act is quite draconian, and takes away people's rights. And I'd love to see a will when actually compulsory treatments not needed. (Mental health sector)*

It was also raised that such provision needs to occur in tandem with the universal use of advance directives.

> *We had that approach around what we used to call advance directives. So when people were in a place and could make decisions, but they never really got looked at in times of. So people would say, sit outside when this is happening. For me, this works well, for me, when this happens, this is how you need to call or this type of treatment seems to work well for me. But we work at pace with compulsion, compulsion is a very quick thing. And it has, that seems to be there happen has to happen quickly. And I don't, that's where I don't know what I don't understand. So if we could, sort of, and I don't like the word mandate, it's not very popular at the moment. But if we could mandate, sort of that if somebody is done at an advance directive that has some standing, particularly if it's been done, with my experience with whānau and or support people or other people. So as their as always on the file or was always accessible, but it was never looked at until after. (Mental health sector)*

Those who are cautious about a reduction in compulsion

The mental health sector also stressed that removal of compulsion would effectively risk inhumanely treating an individual in need and risk those in crisis suiciding. We heard from clinicians that the absence of such provision was described as:

> *Doing a gross disservice to those that are most unwell and most in need. (Duly Authorised Officer)*
>
> *I suppose, unsettling for me in certain respects. But I do think there is a a group within the larger group that have mental health needs that just the nature of their presentation, it's to not have a mechanism to somehow treat that I think would kind of get the point of being inhumane and maybe not achieve what the goal of no compulsion will achieve. (Mental health sector)*
>
> *No compulsion would lead to an area that I think of risk for the individual that I think will be hard to manage without a compulsive element to the legislation where I come from an Ireland, they did they don't have a compulsion in the community setting. (Mental health sector)*
>
> *I would be really worried that there would be people a bit huge risk, and they wouldn't be getting what they really needed. And that it would, it would result in people losing their lives, basically, I mean, actually losing their lives, or losing the way of life and all the expectations that they would have had for how they would have wanted it to be. (Mental health sector)*

Concern was raised that those who are unwell, without appropriate mental health legislation risk entering the criminal justice system, as opposed to being assisted by the health system.

> *"And I hear that quite a few of them would, instead come to the attention of police and allows me to help stepping in to kind of address the mental health needs. There may be a lot more than we could call under the kind of forensic umbrella. And that's something we definitely want to avoid" (Duly Authorised Officer)*
>
> *I think we would see more people in the criminal justice system, we already see what we're, you know, people end up going into the criminal justice system when they're actually ill, because they haven't been aware of that, or they haven't been willing to access treatment.. And I think we would also run the risk of losing some of the safeguards for people, because if you haven't got a structured Mental Health Act, which allows you to treat people who have no understanding insight or wish to be treated, but they are at significant risk for, you know, of whatever other people can step in, actually, sometimes that's, that's family members, sometimes they're taken advantage of by other people. And so there would be no way of us, if you like, regulating or monitoring that the types of treatment that people are getting, because it wouldn't always be the treatment, in countries where this isn't very well regulated, you do see, you know, abuses going on. And I'm not saying that this is an abuse of society,*

> *but people would then be left to try and manage situations as best as they could, because they wouldn't be a way a recognized method of being able to treat people who are in desperate straits. (Mental health sector)*

Others instead framed a lack of compulsion having negative consequences for community members.

> *Coming from like the emergency department, when we have a lot of people come in here that are particularly paranoid or agitated. If we didn't have any compulsion, ideally, like, we wouldn't have any way to hold them, and treat them effectively. So we'd effectively just be opening the door and letting them walk out to the community. And that would be really problematic. I think for you know, our community... I am concerned if there was no compulsion, that there would be problems in the community. (Duly Authorised Officer)*

While the necessity of compulsory treatment orders was raised by the mental health sector, we also heard that it is important to implement such compulsion without adversely affecting the individual.

> *They don't have like the CTO they have here. And I think that can be I agree with that. Because I do think there, you can do that without necessarily adversely affecting the individual. (Mental health sector)*

IF THERE IS SOME COMPULSION WHAT WOULD IT LOOK LIKE?

We heard from the mental health sector that mental health legislation needs to adhere to a human rights framework and international conventions, such as the Convention on the Rights of Persons with a Disability and, in particular, Article 12 which states is outlined in the following table.

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

Within this context, we heard that new legislation should position the individual's rights to decision-making within a context of their wider social support structure, albeit whakapapa or metaphorical whānau.

> *You'd start from a different premise altogether. So you would have to do that, I mean, the whole thing of Article 12 of the CRPD, about supporting decision-making, you'd have to bring in a process that really was centred on individual and whānau, that had a lot more about how decisions were made, rather than decisions being made by somebody with power outside, just saying this, you know, looking in and saying this person is, you know, giving them a label. So I think no compulsory, I think that would just mean you'd have to start totally from the other end, from the, from the bottom, from the family, from the community. And using all those methods that you can, if somebody was not in a position to actually communicate, whatever with words or with, you know, we're just using behaviour to communicate. So you'd have to, people would have the whole system, he would have to look at their own ableism and their own prejudices, to rather than looking through their prejudices to see what's happening, you know, have to be a much more informed process. I don't know how you enforce it, (Mental health sector)*

Participants' compulsion-related perspectives fell into two primary areas: conventional perspectives and an alternative approach to compulsion.

Conventional perspective

Those aligned with a conventional perspective noted that compulsion should be time limited and of a shorter duration. We heard that such time-related requirements should be clearly stated in the legislation.

> *We haven't definite treatment orders which people just sit on for years. And I suppose that seems like one good place to start really simple. You know, having them time limited … Yeah. So, making changes in that area.. that's all I can think of right now. (Duly Authorised Officer)*
>
> *Yeah, would have to be very, very time limited. So people just don't get stuck in the system for years and years. And so very clear pathways out. And I think in our current legislation, pathways out have really had so yeah, so short, sharp, you know, the short, sharp but supportive, and then something else happens, that has to happen. (Mental health sector)*
>
> *The sort of indefinite order type situation I really struggled with, I've always found that difference. It's difficult since I got here. I think there is a role for some community compulsion. But an indefinite order, for me feels like a lack of regulation and a lack of, you know, the, there aren't reasonable safeguards and reviews in there. (Mental health sector)*

We also heard concerns from mental health professionals that there needs to be better reviews and safeguards embedded in a mental health system that is supportive of the individual.

> *And as a clinician, sometimes I would really, really like there to be more reviews. Because as a clinician looking after somebody, when you've got them under mental health, that is sometimes you really do worry about taking people off and then getting unwell. It's a terrible thing to do that and watch someone deteriorate, because they you know, and then end up going on the act again. And with all the, you know, the the effects it has on their lives. And also sometimes they never get back to perhaps where they were before that happened. But I do think there needs to be more safeguards. (Mental health sector)*

Alternative approaches to compulsion

Alternatively, from others in the mental health sector we heard that people have been placed under the Act because of an erroneous interpretation of an individual's presentation, and importantly, factors that occur outside of the legislation, namely a risk to self or others or an inability to care for self. There was concern that that compulsion-based decisions have been made on the basis of the individual's perceived aggression, rather than actual aggression.

Equally, we heard from some of those in the mental health sector that decisions pertaining to compulsion have been made according to the clinician's subjective assessment. In these cases, we heard that people have been placed under the Act in accordance with criteria that sit outside of legislation, namely essential treatment is not a consideration under the Act.

> *When I was reviewing incident reports, I can tell you when they're currently allowed is when people are out when we went when the health practitioners believe that this essential treatment that needs to be given. That's currently what I see a lot of a lot of the incidents are based on that. On what, but I'm not sure who perceives what is essential, but it's most likely going to be the clinicians perspective, because they fill in the incident report. So yeah, maybe that's that comes to question like, who makes the decision of what's essential and not? And where is the documentation for it? Is the whānau involved? Or has an Advance directive been made? (Mental health sector)*

Multiple concerns were raised about this decision because, in many situations, insufficient or no efforts have been made to understand the individual's perspectives or gathering the perspectives of significant others and peer support workers. In these situations, we also heard that people have been coerced by mental health professionals to go under the Act.

> *Okay, well, I'm not I'm not particularly a mental health person, you know, in that sense, but in compulsory treatment be allowed. Well, just from looking at when I was reviewing incident reports, I can tell you when they're currently allowed is when people are out when we went when the health practitioners believe that this essential treatment that needs to be given. That's currently what I see a lot of a lot of the incidents are based on that. On what, but I'm not sure who perceives what is essential, but it's most likely going to be the clinicians perspective, because they fill in the incident report. So yeah, maybe that's that comes to question like, who makes the decision of what's essential and not? And where is the documentation for it? Is the whānau involved? Or has an Advance directive been made? (Mental health sector)*

> *Sometimes because, you know, our workforce is under immense pressure. You know, and sometimes, when people are under immense pressure for so long time, they tend to choose the easy way out. And that's something that you learn over time. And, you know, and that's, that's why it's important when it When, when, when, when creating and developing and, and maybe that's something that legislation can look at is around education and support. And, you know, for educational support for, for the workforce, something like supervision, like, we don't really have supervision in general health, you know, you know, for the workforce and things like that as well. (Mental health sector)*

> *There's a fine line between compulsion and coercion. You know, and that's where assessing capacity could be fraught a little bit, you know, so the workforce also needs to be honest, and authentic, about what's happening. Without coercing people towards compulsion. (Mental health sector)*

Concern was raised that compulsion-related decisions often occur because of insufficient staff resourcing. As a result we heard that compulsion-related decisions are not necessarily based on the individual’s risk but are a response to the allocation of resourcing. As such, we heard that such decisions should be viewed as an infraction of human rights.

> *And he's doing so before somebody will be under the Act before, why they may be still trying to assess somebody who's got the capacity to know what's going on, also have their bias. (Mental health sector)*

> *You mentioned things like, sometimes you have to make those decisions. In sometimes quite dangerous situation, as well. So it's really, it needs a lot of skill, but it also needs a lot of resources around as well like, like, if you don't have cultural support available at that time, you won't have it. So there has to be cultural support available, all the three shifts, you need to have access to whānau communication … available all the time. Every time we need to have the support available every time we can. Because you don't really know when just like, although there might be incidences more to say a particular time. But maybe that's because that time we probably isn't enough resources or or there's something going on in the environment that is stimulating people or we could be educated. (Mental health sector)*

> *That's what we kind of been interested in the data looking at times, the times that time today, police are involved, as the act more likely to be used as a quick was an easy solution to resolve something that's happening late at night. There may be other drivers why compulsion series to the act is applied. (Mental health sector)*

We also heard from some of the mental health sector that compulsion should not equate to the individual losing their ability to decide aspects of their treatment.

> *I suppose for me, just something I thought about when we're talking about supportive decision-making, I think one of the problems with compulsion is that it's either there or not. And I think like we're on the Mental Health Act or not on the Mental Health Act, and it's quite narrow in the regards of what that means for the person, day-by-day. And I think if we're looking at a supported decision-making, why can't there be layers to that what that compulsion means it doesn't have to be like a one big lump, you're under the Mental Health Act, it could be that for example, you know, a certain aspect of treatment might be something that, that that could be part of a compulsion, but maybe not the rest of what they're doing. Why can’t we say, “Look, we could have a level where it's like your medication is as, as part of a compulsory component or your attendance to something as part but you're not going to be an inpatient”? And then we work together. Because it's currently like one size fits all. (Mental health sector)*

> *I think that, that even at the heart end of someone being admitted for the mental health that someone who's been in before and has got some experience of what it's like, there is definitely room for people being able to have some sense of some control over even if it's a very small area. I think medications is a really good one. People, some people have absolute meditations that I really hate. And it's really, you know, for something else that works for them, let's, let's just go for it. (Mental health sector)*

TE TIRITI O WAITANGI

Mental health sector participants described an appreciation of the significance of The Treaty of Waitangi but also a lack of clarity surrounding how the Treaty might be embedded in new mental health legislation.

We heard acknowledgement and appreciation from the mental health sector of Māori overrepresentation in mental health system and that the impact of colonisation and racism cannot be underestimated. Issues negatively impacting on Māori are outlined in the following table.

Issues Facing Māori	Description
The need to engage tāngata whaiora earlier and engage in mana enhancing practices	Māori present later to services and have a lot more issues in terms of finding the services responsive and, and the place they want to engage. And so I just think we've, this comes back to the resourcing of the whole mental health service and thinking about how we set mental health services up, because we need to make mental health services a welcoming place for people, for Māori people to come to, and I'm not sure we've got that right at the moment. Because otherwise if we don't engage early enough we run the risk of more compulsion. (Mental health sector)
A disconnect between western mental health frameworks and the way in which mental health is viewed within te ao Māori	I think that within the mental health legislation is the disconnect between the te ao Māori worldview in terms of how illnesses is viewed, like whānau, hapū and Iwi. And sometimes that translation between, you know, this person has a, say, a psychotic illness, and that requires treatment, but there's no effort made to try and frame that within the overall health of a person from a te ao Māori perspective. And I think that's one of the missing pieces in the legislation. (Mental health sector)
Māori receive appropriate support that meets their cultural needs, be that through a kaupapa Māori	The people who say don't want to access kaupapa mental health services, what we find is that, that disconnectedness and they don't feel comfortable into that space is actually one of the one of the factors that is actually, part of the trajectory to on wellness, is that disconnectedness from their whakapapa, So I think for me, it's about, you know, making sure that legislation needs to frame services in te ao Māori as a general rule, but also, I think that the needs to be more inclusiveness of Māori supports and resources within standard mental health services are not kaupapa to make sure that that is being the Mental Health Act has been used correctly

service or a mainstream service	for that population that at that, who, at that time, don't want necessarily a kaupapa Māori service, but doesn't mean that they can't begin a journey back to their whakapapa in a general service. Does that make sense? (Mental health sector)

Rather than referring to Te Tiriti principles or articles, the mental health sector referred to the importance of key aspects of te ao Māori being reflected in mental health legislation.

Te Ao Māori Tenet and Operational Considerations	**Description**	**Quote**
Rangatiratanga of tāngata whaiora[6]	Safeguarding the needs and enhancing the mana of tāngata whaiora while working in partnership with whānau	*There's obviously going to be situations where family can even in some cases be obstructive, you know, that's very rare. Or sometimes, I mean, I don't know what your experiences are, but sometimes people using mental health as a way to get family out as well. You know, we've come across that. So there has to be some way of balancing it doesn't't. (Duly Authorised Officer)*
Whānau	It is essential to appropriately engage whānau in a mana enhancing way. In addition, whānau should	*I suppose one of the obvious things that springs to mind for me, as you know, is whānau involvement really, in the moment, there's, you know, there's a requirement to talk to family, you know, during the initial face assessment stage, but that's kind of about it, really. And I wonder whether we should be thinking about family involvement, you know, review, review stages, and just generally*

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[6] Participants about rangatiratanga in relation to individuals. It is acknowledged that rangatiratanga is typically understood to be about collective rights (for example, tāngata whaiora in the context of their whānau, hapū and Iwi) and not in relation to an individuals rights.

	be empowered to make decisions about the needs and health of the whaiora in the event that the whaiora is not in a position to make decisions for themselves	*mandating that on the legislation really. Just to kind of keep that up, really, because once you're under the Act, that's, you know, there's no nothing, nothing in Act to keep, you know, that family contact. (Duly Authorised Officer)* *I very much agree that the whānau involvement is crucial to us. And I think maybe that's something that could be worded differently in the new Act. And there's, I guess, at the moment, it's worded, that we should involve whānau where practical, you know, but we sometimes have halfhearted effort by some clinicians as well, I've noticed. And, and in when you can't get hold, immediately it adjusts on the pieces used… family involvement is pushed to the side, and that's not great. (Duly Authorised Officer)*
	Provision for whānau to be with whaiora while in acute care	*We don't have the facilities and inpatient units to allow whānau to come in and you know, and maybe we would be with them because we consider it too much of a risk and put them in seclusion. (Duly Authorised Officer)*
Mātauranga Māori	Provision for treatment of whaiora should include the possibility of engaging in practices that reflect te ao Māori. Such provisions include: ▪ te ao Māori healing practices (that may occur outside of a western clinical setting)	*We need to acknowledge the cultural life of somebody, and that actually, maybe the solutions or the thing that's going to help them that time actually is within the culture. So yeah, I spent time is as a clinician and was a DOA for a number of years as well. There have been a few times when I didn't think it was a mental illness. I actually think this illness is based on whakama, which is a concept and te ao Māori. But I didn't feel supported to be able to work differently with the whānau. So my hope is that actually those things like going back to the river about, like connecting with the ngahere or the moana is actually absolutely part of the treatment options available. And those wider things are considered. (Mental health sector)*

	▪ ensuring clinical environments include provision for kaumātua	*I think legislation should include preparing culturally responsive environments, in the sense that Māori feel safe. You don't want people to get distressed in those settings, especially from a restraint, seclusion perspective. And te ao Māori can also include having kaumātua and kuia around as well to speak, because people with, with disabilities, and they and others, they respect those people. And if there is de-escalation needed, sometimes having those people around, helps deescalate then just by their mana, the presence, you know, is recognized very easily. So, probably investment of around having those kinds of people around, like from from a te ao Māori perspective.* *I think we invest too much in bricks and mortar or security or places of healing. I think the infrastructure of mental health services, particularly when you're in sort of the end where compulsion has been used and legislation. We're putting people in the wrong places. And I think security and safety and healing comes from a completely different way of looking at our hospitals.*
Workforce development	Staff training about the impacts of colonisation	*I think staff need to be I personally believe a lot of our staff need to go through understanding the impacts of colonization on Aotearoa. And it's not something that happened years ago. It's something that's very real today for many people. And so staff need to understand that sort of the decolonization process, non-Māori staff I'm talking about, and citizen building and just understand their histories. (Mental health sector)*
	Developing a workforce who can respond, and work within, te ao Māori healing practices and	*Having a workforce capable and responding in a te ao Māori way is absolutely critical, like going back to the ngahere. We need to more strongly recognize that because Section 5 of the Act does actually talk about cultural assessment, but when you want it to say was a cultural assessment undertaken, it's pretty rare, actually, in a mental health assessment. So there's a lot in there and think you*

	mana enhancing processes	*can correct for actually recognizing that because what we're actually saying is that the Mental Health Act is applied quite blankly and a one worldview. And so what's the opportunity in a newly reformed Act in order to expand that into include more of the cultural life of people, I'm not just talking about Māori people, we all have a cultural life. (Mental health sector)*
	Adequate provision of kaiawhina and cultural advisors to respond to the needs of whaiora. Special mention was especially made for the need to ensure sufficient staffing occurs during evenings and weekends	*And the only other thought that I had in terms of how we can beat te ao Māori model into it more as you know, all of our crisis team, all DAOS we are we are clinicians, and we forget the true skill of our support workers or our kaiawahina. Or, you know, why have we not got those people working alongside clinicians on a crisis team, while we own one, we only got clinicians on advices time, you know, we could have a very different model if we had a crisis clinician and a cultural worker at the same time. So that's my thoughts (Duly Authorised Officer)* *we've tried to do quite a bit of work around this with our inpatient unit and the cultural advisor that works there. So that's around, you know, talking to the family talking to the client, and then talking to the cultural advisor, or asking if they want any cultural involvement to start off with. And then if we are looking at moving them into the inpatient unit, having the cultural advisor there to welcome them when they arrive. We've also done quite a lot of work and having families help transport across generally, previously, in the past, it's been a transport that goes with security. So you have this person and they're all settled, you've got a relationship with them. And then you need to transport and you have to do that with security well, from the hospital to the inpatient unit, we that's the only way that we can safely transport regardless of whether they going into a high care situation or an open Ward situation. And then all of a sudden, you have like three*

		security guards all tuned up, you know, with the jackets on and the cameras on and the blue gloves, and they're all walking in. And, you know, you've had a conversation with the person who's unwell trying to explain that this is going to happen, but that's really scary for them. So we've tried to sort of take that away, involve the family, let them know. And we found that the transports with the cultural adviser, welcoming them on to the unit, and then having a conversation with them , a reduced amount of the tension security call outs, any kind of anxiety that they'll have going in there. So we've started to try and do that. But I think that, you know, we don't do it as often or as well, especially in the COVID that all kind of got scattered because no one's then to the wards at the moment. So we've only got us going across without family to the wards at all. And we know that for for a lot of them, having family around us caring and deescalating for them. So, you know, having that option for people would be much better. I think in terms of recovery. (Duly Authorised Officer) *On the weekends, it's really frustrating after hours, you know, it would be great if we had someone available to us in the hospital, even just to have the conversation, I mean, we've got some of the security guards who are Māori. And we actually find that even them having them around is beneficial. We've moved away from watchers, we have what we call therapeutic observers now. And one of them is Samoan gentleman, so he works predominantly in the emergency department with mental health clients. So he goes in and talks to them. And he has a really calming presence, which has taken away a lot of the code oranges, a lot of the aggression that we had been having previously. So he's good, but he works sort of a Sunday through Thursday. But no, we would love to have cultural support 24/7, it would just take the heat out of so many situations. (Duly Authorised Officer)*

CAPACITY AND DECISON-MAKING

Introduction of a test of capacity

We heard mixed views on the need for a test of capacity as an element of compulsory treatment from the mental health sector. In the main, however, we heard support for the introduction of a test of decision-making capacity as an element of compulsory treatment

Less supportive positions

We heard from some of the mental health sector that those who fall under the Act are in crisis and have been determined to be a risk to themselves or others. Within this context, the introduction of a test of capacity could lead to risk, namely the possibility that someone might meet a test of capacity but be a risk to themselves or others.

> *Yeah, for me, was it was a capacity issue in terms of compulsion. Yes. I mean, I think at the point where it can be acknowledged that capacity isn't no longer there, I think obviously, that puts the person in an incredibly, you know, the mental health Mental Health Act talks a lot about risk to self or others, you know what I mean, but like, you know, for me, it's meant the vulnerability of the person in that space, you know, because they by the nature of the illness are experiencing if they're incredibly elevated, or if you know, are responding to things that are maybe altering their perception of what's going on around them, and they're in a very vulnerable place. That might lead to risk. But you know, the vulnerability, I think, is the best thing that concerns me. Well, (Mental health sector)*

Further, because the Act can only be used in an acute situation participants suggested it would therefore be rare for capacity to be present at these times.

> *Oh, look, this is I think this is such an interesting one. And of course, I've never worked in Scotland. But I know Scotland has based its Mental Health Act on the issue of capacity. And so I was over in the UK at that point when they made that break. And I used to try and think through how would it make any difference. Any true difference to people who were who came under the Mental Health Act or not, because thinking about when you're using it, particularly in an acute situation, you know, capacity is about understanding your condition, understanding the benefits of treatment, the, you know, the problems of not being able to get treatment, being able to weigh that out up, and make a decision without coercion, and to be able to communicate it back. And so, actually, the situations where you see the Mental Health Act being used as it stands at the moment in the acute setting, I wouldn't see that I would have thought everybody would not meet the capacity test. (Mental health sector)*

We also heard that there is a possible problem with the definitions surrounding capacity. This was especially raised in non-acute situations when an individual chooses not to engage in treatment. In these situations, the introduction of capacity would result in an inability for clinicians to make treatment compulsory.

> *I think I think like you're saying, Martin, it probably becomes more difficult when people are not acutely unwell. And you could have people who don't have capacity because they don't have insight, because there's a huge overlap between capacity and insight. And so they, you could say they don't have capacity, so we could treat them but just like you're saying, you would want to know that there are real significant risks attached to that, to know that you wanted to go through and treat somebody when they don't, but when they don't want to be treated. So I know, you could say that someone who can't see that there's going to be risk associated with not being treated would come under capacity. So, you know, that could work to its I've always struggled to see whether how much benefit changing that would bring us but I guess it would, it would it would be a well-known framework that we're used to working within in other branches of medicine. So I think it would bring that kind of nice consistency and it would perhaps reduce some stigma between you know, the branch of mental health and others. (Mental health sector)*

Supportive positions

We heard from some of the mental health sector that mental illness is episodic and placing someone under the Act can have long-term implications.

> *I think that's a really hard call to make, because we start the act, because when I when I guess people have lost insight, a lot of the time we're taking that into account anyway, they don't have a guess, the ability to make good decisions at the time, which is why we've kind of stepped in anyway. But mental illness is episodic. So to make a decision, at the time that we put someone under the end to the long term implications of not accepting treatment. That's a really, I think that's a really hard decision to make. (Duly Authorised Officer)*

Because of the risk of trauma, participants related that decision-making capacity should be included in new mental health legislation, but that capacity should not be solely determined by a clinician. Rather, capacity should be determined as a result of a holistic process centres on the individual's capacity and draws on the perspectives of peers, significant others, and clinicians.

> *I quite like the idea. But again, I've got no thoughts actually on how we could make it a reality. To be honest. Assessing capacity is something you know, in our environment that, you know, only the doctors do. Well, you know, in terms of like, formalizing capacity is clinicians, we would usually come down and have an opinion, you know, on that. It would be something that I would be hesitant to be saying, definitely, until I've had a decent conversation, and sometimes we don't have access to doctors immediately and you having to make decisions sort of for someone's care, I would be a little bit worried about that. I like the idea of but I'm not sure how well we will be able to implement. (Duly Authorised Officer)*

> *In most current situations – the person at the time meets the criteria in Section 2 of the Mental Health Act and they also lack capacity, therefore at the pointy end it is less of an issue. Where the issue of capacity becomes complicated is after the acute stage when the person is becoming well, as capacity fluctuates. I also wonder who the person is who will make that call? It is relatively easy to teach DAOs the definition of mental disorder and how to apply it, but capacity is less clear. A very fine-tuned assessment would be needed to test for capacity. (Clinician)*

We heard that decision-making capacity should be included in mental health legislation and that capacity should be reviewed at regular intervals once the person enters acute care.

> *Capacity that I thought I really like that idea of short term, I was quite horrified to hear it in a meeting that people can be put under the Act and it lasts months. And the reviews, they don't even have to be involved in the review, somebody can do the review from a distance, I believe. So they don't even have to actually involve the patient in the review of whether they're not or not their fit to get out of the mental health system. Whereas to me, it kind of seems like a no brainer that that person, nothing about us without us, they should be involved in the process that sees whether or not they can, they have the capacity to make decisions for their own life. Rather than some psychiatrist who looks at the notes and sees now they're not fit for it. (Mental health sector)*

Tests of decision-making capacity – issues to be resolved

Despite some support for the introduction of a test of decision-making capacity we also heard a high degree of uncertainty from the mental health sector about how capacity assessment might be operationalised. Concern was raised over how, what and who could assess capacity and whether this could be moulded to fit a model of capacity to be able to place someone under the Act, whilst ensuring safety and treatment outcomes. This was especially raised in relation to marrying an individual who meets a measure of capacity while posing a possible risk to themself or others.

> *I personally like this idea. I think already, we probably take it into large. It's a large part of what we consider when we're assisting someone currently. But to make more formalized, I think it's a good thing. I saw in the documents that Australia or some states in Australia use a capacity. So I'm not quite sure what these would look like. So I can't speak too much about that. How you would go about assessing are a standardized way of assessing capacity. And I guess I don't know what would happen for people that were deemed to have well, on face value were deemed to capacity to make decisions. But there was still risk involved. I imagined that people would just find a way to get around that, you know, if someone was talking about ending their life, but they're speaking in a very rational way, and they appear to have all their mental faculties I think people would just, they would get around that by saying that they're not rationally assessing risk themselves. But for the most part, I think it's a good idea. It'd be a good change. (Duly Authorised Officer)*

> *Yeah, so I don't know how that would necessarily work. It's not that I don't agree with it. But I think I just need to think more around how that would be applied practically, in those situations. (Duly Authorised Officer)*
>
> *It's something we already do, but to formalise it would be a good thing. But I am unclear who we would assess capacity and how we would have a standardised way of assessing capacity. On face value, someone may have capacity but there is still risk involved (Duly Authorised Officer)*

There was also uncertainty surrounding acute presentations in emergency departments and the difficulty, and challenges, incorporating the holistic perspectives of others at such times.

> *It's probably a bit more of a complex assessment and requires information from other people, you know, from, you know, collateral history, or collateral information. And yeah, I just think that it's something that needs more time taken about it, really. (Duly Authorised Officer)*

Participants also related that our disabled community is at particular risk of having capacity inappropriately assessed. This was especially raised in relation to those with neurodiverse conditions, where the physical environment, leading to sensory overload, can exacerbate what might appear as presenting symptoms and negatively impact on the individual's ability to demonstrate capacity. We also heard that accommodation is required for people who are deaf or non-verbal. Within these contexts, staff need to be trained in sign language and assisted or augmented technology should be readily available.

> *And I think, you know, there are situations, particularly neurodiversity from my experience, where there may be a sort of a person who's quite who, well, I mean, it's a it's a knockdown, probably from over from sensory overload of some kind, but it's scary, it's big, it's violent, and people get in. So anybody else, even if people do use words, normally, the words are there at the moment. So I just think, I mean, it's really important in that case for people to be around who understand the nonverbal. So either people could be deaf, so you need people to sign language, you need people who know about or assisted or augmented technology, you need people who understand that person's language, whatever they're using. And but then again, families are not always helpful, they can be quite toxic. So yeah, I think it's a really, really big issue. And I think there has been some work by people, particularly around people with disabilities. So I'd like that to be followed up somehow. (Mental health sector)*

Within the context of such uncertainties, we heard that adherence to advance directives is essential to ensure the individual's wishes are followed.

> *I think the whole thing around advance planning. I just think we so have got to get better at that. I mean, I think that's so key. And involving, obviously whānau when people really don't have capacity or able to make those decisions? I mean, gosh, we've got to get better at that. (Mental health sector)*

SUPPORTED DECISON-MAKING

Participants suggested that supported decision-making is difficult in acute situations because it is time and resource intensive. We also heard that a lack of staff willingness and knowledge precludes this type of commitment.

> *That's quite a long time and time as if you've got the time and space to actually do that. So If you're if you're able to actually even just sit, and Dean will talk about this, you'll talk around in the seclusion context when what happens prior to seclusion, to being able to sit in talk and talk through, you know, better for sort of under pressure, we have to move on, we've got these other things happening in our work, like, you know, that all gets lost. So the time had heals many of other, you know, physical health ailments. Time to sit and consult and make does the, you know, make a good decision for everyone. (Mental health sector)*

It was therefore emphasised that supported decision-making requires a commitment on the part of the mental health system. We heard that the mental health system would need to adapt and dedicate sufficient time to meet with the individual to discuss the individual's needs and preferred treatment pathways. We also heard that tāngata whaiora have the right to include those most important to them in their planning discussions. It was noted that kaumātua and kaiawhina, peer support workers and advocates need to be included in the process. It was stressed that supported decision-making, and ensuing plans, should be a legislative requirement.

> *For me, supported decision-making would look like you know, where the patient has place at the table. Now that this can be this can, this can happen before the incident happens, it can happen even after like in a debriefing kind of thing as well. So like, although some would say support distribution, of course, involve the patient, but it's also involved things that matter to him, like their whānau, or things that matter to him, like maybe their cultural support, you know, sometimes appears, or and also, maybe people have their multidisciplinary team before things like big decisions, like putting people under compulsion happens. So I know it's probably considered a very serious thing anyways, but I think we probably need to dot more eyes and take more T's and, and have more not maybe cultural set cultural, safe cultural approaches and stuff not as a nice to do but more as a must do. Maybe that that's probably what legislation can help by making things that are commonly treated as a nice to do into a must do. (Mental health sector)*

Advance directives

Participants strongly supported advance directives being embedded in the legislation and that the use of advance directives provides whaiora with greater autonomy which is fundamental to a person's wellbeing.

While the provision of advance directives exist, they remain underutilised. We heard that lack of uptake of advance directives can be attributed to clinicians who fail to see the utility of the directives, a lack of knowledge amongst whaiora about their existence and appropriate systems to support it, such as accessing a patient’s record.

> *But I think the advance directive is so fundamentally important, we need to know what's right when the person's optimally. Well, to know how to then proceed when maybe that's not the case. (Mental health sector)*
>
> *I don't know I think that I think there's a lot of contributing factors. And to be fair, I'm not sure if people truly understand what a good Advance directive could do. And how that could be utilized better, I certainly a number of clinicians would probably come back and say, Oh, just it's just another piece of paper we have to put down. It's just another thing that we have to do why we have to do that. So I think some of it comes down to a changing culture in our workforce. what that would look like. Yeah. (Duly Authorised Officer)*

While we heard strong support for advance directives participants stressed that the development of advance directives need to be appropriately undertaken, resourced and in accordance with the holistic inclusion of tāngata whaiora, whānau or significant others, cultural advisors, support people and the clinical team.

> *A couple of things that really struck me when I did my thesis stuff was around that clients had no common understanding of what they felt capacity assessment should have involved, they all had really different opinions, because they're all really different human beings with different experiences with mental illness. And that actually, what we boiled down to was that an advance directive should be more about not just about what I want, but how I want to be assessed, and what I want to be considered when I'm assessed. (Mental health sector)*
>
> *Oh, I like advance directives. And I think that's a wonderful place to make the capacity test for that individual, really, really apparent. But then we're talking about the people we know and that we know quite well - how does that apply to the people we don't know well? And how to apply capacity test to someone that's new to service, when we don't know the developmental, psychosocial history and their lived experiences. (Clinician)*
>
> *And my concern around some of that is that we have a threshold around capacity and it becomes an us and them, really, we've got a whānau that want to look out for someone who they want to support but then they can't do that any longer, they bring him in and we’re saying, “they still have the capacity, you have to take them home again”. So that's my biggest fear around the clarity around capacity and the consistent application of what that might mean for different individuals and families. (Mental health sector)*

Participants raised that advance directives should be extended to those who are not under the Act. We heard that this should be a normalised key practice for all people using mental health services; reinforcing the need for people to be actively involved in treatment and care decisions, and that such provisions should be included in new mental health legislation. We heard the normalised use of advance directives would require a system change to ensure that these were easily accessible and created in partnership with tāngata whaiora, whānau or significant others, cultural advisors, support people and the clinical team.

> *It'd be great if everybody if you know, we had a whole culture of everybody doing some advanced planning for all of us at any time, you know, because it's a big, it is a big gap in a lot of our lives. And my daughter is a counsellor and a hospice. And you know, people get to try and do these things, you know, when it's a time of stress. So I think that'd be really good if we sort of taught that or had some way of making that such a normal thing to do. (Mental health sector)*

> *I actually think advance directives is we should be using them more …. just irrespective of whether you're on the Act of not, let's just be part of the work that we do. And we do fail people in that area a lot. So I think that's not necessarily. That doesn't mean yes, it should be for every person under the Act, we should have an advance directive. But actually, I think it's just we need to improve the work that we do. Anyway, so people don't necessarily end up under the Act. (Duly Authorised Officer)*

> *I like advance directives. And the reason I say that is because in the eight years that I've been around to doing this, I've only ever seen that one. So it happened last week, actually in it was really helpful. It was really clear it was the lady that is was well known to mental health services. But we had a lot of information on the advance directive, which made the decision around what care we provided her were able to provide her really, really clear. So that was that was nice to be able to have that, you know, that documentation. (Mental health sector)*

Participants noted that the provision for the development of an advance directive should centre on the needs and wishes of the whaiora and that the whaiora have the legislated right to support to develop an advance directive through a range of people who will assist whaiora to develop a directive that addresses their holistic needs and wishes. We heard that holistic perspectives should include: cultural advisors, clinicians, legal experts, significant others and peer advocates.

> *Yeah, look, I like the idea of advance directives as well. The other thing that comes to mind is family as well, again, you know, the importance of their, you know, involvement throughout the process (Duly Authorised Officer)*

> *Families are not always helpful, they can be quite toxic. (Mental Health Sector)*

> *I use I was just thinking in that conversation, some way of peer support. So, I mean, there's a couple of things with medication often say, for people with autism medication doesn't work is it's expected. So often medication is a problem. But it's yes, or*

somebody. I mean, depends, depends. But some people have a person who gets unwell, you know, heavy neurodiversity, and they get so unwell. And the families know it, and they know what works, but they just get overwhelmed. And that case, some sort of removal to it to, you know, something that's calming with maybe some peer support that they have identified previously might be the right sort of situation. Sometimes, you know, everything is there family might be estranged. So there aren't any support any, any actual, any support as anybody who understands. And it's often the people who may be deaf or neurodiverse, too. So they just the communication with the world is always problematic. So yes, I think if we had some sort of, if we had some sort of system where we actually say, these are the people who who can support me that I trust, this is what I would like to happen. (Mental health sector)

I wonder about some some kind of cultural advisors or you know, kaumātua or or, you know, again, it's about what we were talking about earlier, people having access to cultural support, you know, outside of ours, and that usually fairly limited. So, you know, if there could be, ou know, mandated in the ACT somehow might be quite useful. (Duly Authorised Officer)

RESTRICTIVE PRACTICES

It is acknowledged that restrictive practices exist on a continuum and that many mental health inpatient units, while categorised as open, are actually restricted because they are locked. Restrictive practices may also include coercion whereby the individual is threatened with being placed under the Mental Health Act or are threatened with seclusion.

Reduction or elimination of restrictive practices

We heard that the mental health sector and duly authorised officers supported the reduction of the use of restraint and seclusion. However, they unanimously suggested that restraint and seclusion is a necessary in some situations and the elimination of seclusion and restraints would prevent clinicians from keeping the individual, other tāngata whaiora and staff safe. In this regard, we heard the potential use of restraint as an option needs to exist in legislation.

> *I have worked in acute inpatient units and my time as a nurse, and it's hard to get away from the necessity of it sometimes to protect both the staff and also the person from self-injury. (Mental health sector)*
>
> *Well, look, I guess I come with a fairly slanted view working in a, you know, forensic unit and having worked in forensic services from, you know, much my career really. And, you know, we manage some fairly high risk people in fairly acute phases who come with histories of, you know, serious offending and high risk to others really into themselves. And I struggled to see in this in this particular environment that that I work and anyway, how we could completely eliminate seclusion. I mean, we do, you know, we have a lot of, you know, we work hard on reducing exclusion. You know, there are a lot of lot of other things we can do before we get into that. For Me, it would be, you know, a pretty difficult place to work without, as, you know, as a last resort. So, my feeling is that there does there does need to be the option for it to remain and the certainly for now, anyway. (Duly Authorised Officer)*
>
> *So, I don't work in an inpatient unit. And I've never worked, worked in a in an inpatient unit, I've only come from a community background, and now in ED. But essentially, within ED, we face it, we do use a form of seclusion. You know, like, if we've not got any beds to most someone turn in ad for like two or three days, they are having to remain in, you know, sort of one little room and we'll have like a therapeutic observer or one to one watch on them. And I really can't move sort of further outside of that. So we are effectively secluding them and away, despite the fact that we're not saying that they're secluded. I have heard of some, you know, instances on the ward where seclusion has probably been the best option and keeping both the person safe. staff and clients. So I'm not sure I know that they worked really hard in the ward not to seclude people, but I'm not sure how we would be able to move forward if that wasn't an option for people who, you know, do poses a significant risk to themselves and others. And like our inpatient unit as well, although they are the ward they are locked*

> *open wards. So to get in and out, you need a staff member to swap and then swap them out and this for anybody coming in, you know, families stuff. So, you know, that probably needs to be looked at too. Before we moved into the new building an open Ward was a true open Ward, the people were able to come and go, but when we moved to the new building, that all changed, and I'm not sure I can tell you the reasons behind that. (Duly Authorised Officer)*

> *I started working in mental health in 2005. I think there's been a massive positive shift in terms of seclusion and restraint in the time that since I started, I think, look, I think there is still a role for that, in mental health, a necessary role. I think sometimes even still, it's probably overused and abused slightly kind of the threat of seclusion or maybe secluding people when when other options could be used. But I think it is an unfortunate necessity so but I know there's a lot of assaults on staff and other service users that still happen in Tiaho Ma people are very unwell coupled together with all the other issues. So yes, I mean, I'm fully supportive of restraint and seclusion minimization to the extreme, but I think it is still necessary part of what we do. (Duly Authorised Officer)*

However, we also heard from the mental health sector that the process of seclusion and restraint should be time limited. Participants suggested that legislation should explicitly state that the individual should be free from restraint as soon as they are no longer actively attempting to hurt themselves or another.

> *I think it really, really has to be time limited. (Mental health sector)*

Environmental and workforce considerations

Participants suggested that practices of seclusion and restraint would be greatly reduced if a number of environmental and workforce considerations were appropriately addressed. We heard, however, this would require a major shift in the way that those with mental health challenges are supported.

> *It all comes down to what we really value as a society. And as the country, you know, if we value something, that's where we will invest, we don't value something really, then we won't invest. (Mental health sector)*

The mental health sector related that acute inpatient environments and a lack of de-escalation skills amongst staff can exacerbate someone's distress. For those with neurodiversity, low sensory environments and the acknowledgement that the individual might chose to isolate were purported to greatly reduce the need for seclusion and restraint.

> *Instead of understanding how best to do communicate with the person, say with neurodiversity, a lot of other stuff has happened that the people doing it don't realize so you get to this extreme situation with and then there could be you know, restraints and seclusion which, which exacerbate rather than rather than lower the situation so I mean, it's all to do with understanding about de-escalation, low sensory, safe, safe*

> *spaces, quiet and and a lot of places there's no quiet there's no low sensory, there's no peacefulness that is what's required. (Mental health sector)*
>
> *I think as, as was just mentioned earlier there, I think, an order further to be a reduction in the use of restrictive practices within the legislation of the Mental Health Act, there needs to be that's only one side of the coin, I think, like the environment that people who are an inpatient settings need to change quite drastically if we're going to take that approach. Because I think that the environment is not conducive to a low restrictive practices, it's quite confining, it's quite small in terms of space, it's not generally a very pleasant place to protect. There are some very nice units, but there are some not so nice units, that I think, you know, it's the basically a tandem approach to this, if they know, the better the environment the person is in and the more low stimulus areas as opposed to restrictive areas, then I think that would work. But I think just to bring in legislation that calls for it without necessarily looking at the environment, the person's end is only going to get us halfway or make things just on manageable in terms of trying to achieve something that can be achieved in a space. (Mental health sector)*

We also heard from the mental health sector about the positive impact of staff who possess person-centred and de-escalation skills as a significant factor in reducing the need for seclusion and restraint. Sector participants stressed that there is a need to ensure all staff are trained in de-escalation techniques and practices, that appropriate cultural input is available, and all staff should have a thorough grounding in when to use restrictive practices. We heard that legislation should require organisations to ensure staff have a shared understanding about the enactment of restrictive practices and the consistent use of risk assessment tools.

> *The physical environments are either conducive or contribute to restrictive practices. It's definitely the people interacting with WIOA who need to be well trained familiar, but then to visit the part of where processes need to be considered processes and systems such as risk assessment tools as early as possible, including conversations with the consumer, to have a good understanding on when we as an as an organization would use these kinds of practices. (Mental health sector)*
>
> *My experiences with it, if I had a Māori help with which me, which is what my, my practice was, you know, that that often really helped deescalate a situation, especially in the community. And so it is about, you know, how are we supporting someone, you know, we know that, you know, Dean would talk about that he's able to go and have a conversation with someone rather than four or five people going into a room because you just see the escalation. So thinking about taking a different view on it, we're at may be needed at one end of the continuum. But we need to have tried, perhaps everything else in there does go bust. But there are strategies in looking help manage that. (Mental health sector)*

Sector participants described how peer support and cultural workers working in inpatient units has resulted in a reduction of restrictive practices as peers and cultural workers have been able to de-escalate situations without the need for seclusion. It was emphasised that legislation should allow for peer and cultural workers as an integral members of acute mental health facilities.

We also heard from the sector that legislation should require organisations to engage in follow up processes with tāngata whaiora who have experienced restrictive practices. The spirit underlying such processes would be to assist tāngata whaiora address possible trauma arising from enlisting restrictive practices and to develop a strategy to avoid enlisting such practices in the future.

> *But also, I think, if it ever occurs that there will be postvention support as well. So afterwards, because often what I would I at least I work in corrections environment. People who have experienced this are left on their own devices to process all of it, which makes probably the future even more risky. Because we do know that we, we contribute to trauma, we don't offer any alternative coping styles for future similar situation. So I think there's also a section of postvention, that probably needs to be looked at. (Mental health sector)*

Advance directives

Sector participants raised that decisions around seclusion and restraint should be informed by an individual's advance directive. In these situations, advance directives were suggested as a foundational to the development of the individual's treatment plan.

> *Just like it goes back to my earlier thing around advance directive. So when something happens, your decision, somebody has already made a decision for you. So about Wait, there is always that opportunity to go back and say, look, what, what could have happened better? What? What have you like to happen in that situation? (Mental health sector)*

We also heard, however, that non-existence of an advance directive is problematic, for example those presenting in an acute unwell state for the first time. We heard that seclusion and restraint in these situations remains a challenge.

> *And what's created that so I think that, you know, if we think about, it's great if someone's already got an advance directive, and you know, here's a plan of what might happen. So that's great. But if it's a first time, so it means that someone has to have gone through an experience to get there. And that means we know that often, the first experience for someone is incredibly traumatizing for them and their family. And ideally, you don't want to be waiting to the second or third time, but looking at what are the ways that we can put practices and things in place? You know, one of the biggest issues I've heard from DHB services is about the increase in the methamphetamine, and obviously the drug induced, so how do we make sure that we're keeping everyone safe? And an environment like that? You know, you Richard, you talked about and*

> *being forensic about this, it's about weighing up both sides, but how do we be very people centered around some of that? (Mental health sector)*

Acute mental distress and substance use

We heard a degree of uncertainty in regard to the reduction of restrictive practices for those experiencing substance-related unwellness, namely they were unsure of how to minimise trauma while affording the individual protections. In particular the issue of managing drug induced psychoses was a raised as a key issue.

> *People who present with methamphetamine delirium … some DHBs have pathways for managing that and we need a national approach. That would be useful. (Mental health sector)*
>
> *So I think if we didn't have any legislation to use restrictive practices, we would just be constantly putting the police to callout units, especially with the level of meth intoxication we're seeing. In fact, at the moment, we already have to pull in the police occasionally, we've had our sink removed three times from our seclusion room this week, and thrown at various staff and windows broken and various other things. So when someone is acutely unwell or and acutely intoxicated in that way, I don't think they're a big guy. And they're used to fighting, I don't think there's any option around not using restrictive practices other than to release them into the community and them to be arrested. (Psychiatrist)*
>
> *One of my concerns, has been, and continues to be, the number of people that we end up having to seclude who are the influence of methamhetamines, and or synthetics, both of which are hugely problematic in terms of risk of medical emergency. And I just thank our lucky stars, in a sense that nothing so far has happened in terms of restraining somebody under the influence, but um, so we've already touched on it, I think in terms of where's the best place for those consumers. (Clinician)*

Monitoring and review

Sector participants suggested that legislation should embed safeguards where onus is placed on mental health staff to evidence that efforts to de-escalate have been attempted before seclusion or restraint is exercised. We heard that the spirit underpinning such requirements reinforces that seclusion and restraint is a last resort and that legislation should safeguard against the overuse of such practices. Integral to such safeguards would be a requirement to report such incidents.

> *I'm thinking in terms of the legislation, I wonder how that can be built into the legislation. So how we safeguard against the over use of seclusion, how we might have to evidence that de-escalation has been applied first, or that the offer of low sensory environments, for example, have been offered first, and this is a last resort. But not only that, we just say that it is but that we have to demonstrate that it has been*

> *Cara, Cara Louise great. I like that taking it further around the practice around it. (Mental health sector)*

> *I just wondered if the incident reports of such situations could if the legislation could require a bit more than these incident reports saying, what was happening up and to the point, because what usually happens is there's a record of the incident, and then what happened. But actually, it's what happened, up until that point that could be as more informative, could be more informative, and could even be used for, you know, staff training and reflection. And I'm sure this happens in some places, but it doesn't happen in a lot of places. So there's just the incident recorded and no learning about how we could prevent this in the future. (Mental health sector)*

We also heard from the mental health sector that the use of restrictive practices should require extensive review practices and such practices should be a legislative requirement.

> *It should require a lot of quite intensive and quite deliberate review processes. (Mental health sector)*

PROTECTING SOMEONE'S RIGHTS

Ensuring tāngata whaiora and significant others are informed and understand

Sector participants acknowledged that family and whānau are often confused about the Mental Health Act and are equally confused about the rights of the tāngata whaiora and whānau. We heard that whānau have the right to be better informed and that this right should be included in legislation.

> *I guess just making them aware of, of, of what's going to happen, what what options are what what the clinical staff will be, will be going to say so they know what's what's coming. And that they understand what their rights are as well, just so the whole process is a bit more open, and they're a bit better informed. So it's not maybe so intimidating and overwhelming. (Mental health sector)*

We heard from the mental health sector that tāngata whaiora need have their rights explained to them when they first enter an acute clinical setting.

> *I think the DI [district inspectors] are important. I'm not sure that we probably like we talk about them when we're giving people the arrives, but we don't we tell them that. We can provide them with information, you know, and contact numbers and things like that, I think that maybe what we could be doing is giving all of the information at the time that we're giving the Section 9 and the rights, so they've already got access to it, instead of them having to ask us specifically, you know, because that could be seen as a place of power, we've got all of that information, we're telling them that they can access it, but then not actually providing it to them at the time, where we could probably. (Mental health sector)*

There was feedback that the environment for current Mental Health Act courts was not conducive to a sense of wellbeing especially for tāngata whaiora having to go back to the inpatient unit, even with support of peer workers or family and whānau. There was a call for a more informal process and potential environments like marae or community environment.

> *I'd like to see a like a peer led service that's at hearings by default. Not if you'd like a peer we can bring them up and see if they can be there on the day just it's doing the judicial reviews. The peers are they're just everyday always gonna be there if you want them come over. So like by default, even if you're not used it all the time, and have access to the hearing. And one thing that currently bugs me is how they do the judicial reviews for people that have had compulsory treatment at the ward. So like for the ones that live in the community. Let's go back to the ward, you hated the ward that's really traumatic. Let's go back there and say that you don't need it anymore. Like just the power differentials there. Same again, except the ward we parked like six blocks away. Go up the stairs up the elevators across the road. It's a massive walk. The judge will have a park straight outside combed out like straightaway you feel worthless. (Mental health sector)*

> *But I was thinking about something, something slightly different. It would be cool to see these judicial hearings done like on neutral territory, like you talk about that way. Like, you're more empowered to say what you want or what you feel in your own space. So if it's the medical professionals are coming to your space to do this, or a neutral space, like, it's different when you go to the office that you sit where they want you to sit, you come in when they swipe their card, like you're offered tea and Coffee, when they want to offer you tea and coffee, and you leave when they say leave. If it's on in your space, you're telling them you can come in now, like take your shoes off when you enter like it's on your terms. It's your the chief. And complaints can be dealt with, straightaway, like get up in my house and go in my space or like if you're doing it like a neutral peer NGO office. (Mental health sector)*

We heard that some judges rushed the process whilst others took time to understand the individual’s perspective and needs while also ensuring the individual and their whānau understand the process.

> *And we also have a local family court judge who's relatively new to us who does, he's, he's very judge like, but he's also very good at explaining and taking time. So our processes run pretty, pretty well. (Mental health sector)*

> *Yeah, I think that the variation in judges is, is quite an issue. So we have some judges, a couple of judges who make the whole thing quite therapeutic and that deescalates the tension in the court. Others feel as if they're constantly harangued by judges and treated as if they're involved in the criminal process. So I think education of judges and guidance of judges are a vital part of this, and it should be a therapeutic focus, which is obvious to us, but it does not necessarily obvious to the judges. (Mental health sector)*

> *And I mean, we've certainly heard from people that say that they know some fabulous family court judges that are so inclusive and acknowledging and kind. And they actually depict the Te Tiriti in practice on a daily basis. And it doesn't matter how long it takes to be able to earn the respect of the individual and the family that are the applicants of that process. But what's important is the relationship and enabling them to feel safe. (Mental health sector)*

> *I have had some very good experiences of the Mental Health Act under the current legislation. There's a judge, who he if testified or, and they found I want him to open with karakia, he will do that. He doesn't sit behind the desk. He likes to hear people's stories. His so his hearings often go on quite a long time. I, for three years worked for the Māori mental health service at ADHB. And we did cultural competency training, which made me reflect quite a lot on how did I write the clinical reports. So I would endeavor to to write about the person where they were from the Iwi and their strengths and that kind of thing before anything about illness. And one hearing I recall that went particularly well, who person who'd been very unwell and had acted in quite a deep, dangerous manner. I took a long one of his carvings to show the judge. And that just changed the whole tenor of the whole whole hearing like it. Yeah, it ended up with everybody smiling and walking up out happy even though the CTO was continued. And in my view, you know, it was necessary. (Mental health sector)*

An independent review body

Sector participants offered considerable support for the creation of an independent review body responsible reviewing treatment orders, appeals against being under the Act or extension of an order. We heard that such independent review bodies should replace the current role of the court and the creation of an independent review body should be reflected in the new mental health legislation.

> *I think that it would be good to have a more independent panel, that is, like outside of the, say, the unit or the trading team that has a mixture of both legal and, and clinical people to try and hear in an objective fashion. The arguments, because I do think often the current stance of of using the courts, I mean, you have a judge respectful and whatnot, but it's a case of what's their understanding of what we're trying to put forward here. (Psychiatrist)*

> *You know, when you have a judicial review at the moment, it just doesn't feel right. It feels like we're just setting up that whole power imbalance again. And so I think that it would be really important to have, you know, Māori representation at those key points in time, so that we get it right. (Mental health sector)*

There was suggestion of the need for mental health services to be accountable for actions where all actions needed to be reviewed and held accountable.

> *And actually they then becomes a proper process of accountability is because what the hell else are we held accountable for by the by the judge? We appear before the*

> *judge every six months and what is it that the judge that holds us accountable for delivering? (Psychiatrist)*
>
> *I used to work in [name of country removed] and what we had was … that initial legal step (placing someone under the Act) was, was conferred on the psychiatrists, but our staff were very heavily reviewed by a mental health tribunal. So every patient that went under the Mental Health Act the paperwork, and everything went to a mental health tribunal, where in that tribunal sat a lawyer, a psychiatrist, usually a retired psychiatrist, you know, would do that and social worker nurses. And so it was a whole sort of medical legal ethical tribunal that would go through everything. And if they had any questions, they could summon the doctor to that tribunal or the patient to that tribunal, and the patients could make a submission to the tribunal as well. So the patient wasn't always confronted with this court case. (Psychiatrist)*

We heard that the creation of an independent review body would ease some of the responsibility and risk aversion carried by psychiatrists; risk aversion resulting in the individual being placed under the Act for extended periods of time.

> *I think that sometimes psychiatrists feel enormous responsibility. And the worry of risk, and the fear of people relapsing and their lives being ruined, also weighs very heavily on people sometimes, in terms of their decision-making. So, I think someone who comes in and there was a, there is a reassessment by some independent people is a really useful thing, when, you know, there are times we can't do that. So when we're talking about the beginning part of the Act, when you've got someone who's very acutely unwell, there's not time for all of that. But when you're talking about somebody being on a treatment order, or appealing against their being under the Mental Health Act, or having an extension of an order, that there is time for, for a more robust sort of assessment and an inclusion of other people in that decision-making. And I think that we, as the Act stands at the moment we miss out on that. (Psychiatrist)*

We also heard that there is a need to establish a review body because perspectives of psychiatrists continue to hold the greatest influence and, as a consequence, the individual's perspectives and needs have been minimised or ignored.

> *And I apologize to the psychiatrist on this panel. But there seems to be so much power. The psychiatrists have, and they have always had so much power on our mental health system. But they might not. They might not be the people who actually understand that person's dynamics. And they looked through a lens of medication, and psychiatry training, which, so I found a really good psychiatrist in the system. And there's a lot better ones now. But historically, and even in recent history, there's they have been some of the biggest barriers to people, people's rights, human rights and actually healing. That, yeah, so I think somehow to get more in some sort of monitoring, get more of a community, family perspective into it. (Mental health sector)*

Mental health sector participants suggested that reviewing the needs of the individual should shift from a reliance on clinical expertise to include others who can provide a holistic understanding, beyond western medicine, and support the individual communicate their needs from a lived experience perspective. We heard that there is a need to make such processes culturally safe and to ensure range of diverse perspectives are represented in the review. Sector participants suggested that such review bodies should include clinicians, legal experts, cultural advisors, significant others, lived experience peer advocates, and disability advocates. We also heard that there should be provision for independent peer and whānau advocates.

> *And I think that needs to be mixed with, I think, more advocates that I can make, I think there should be an advocacy component, a clinical component, a legal component to it like a, a panel of sorts that would provide a more balanced and approach but that still safeguards legally, the rights of the of the person under the under the legislation as obviously it is a legal document. But I'd like to see a more even approach to how that is reviewed. That does have a huge advocacy component that does, but also has a technical component that is able to speak on behalf of what you know, or listen to what say the consultant psychiatrists is putting forward as, as their rationale for maybe maintaining some form of treatment compulsion? I think that would be I think, a more comprehensive even way I think, maybe to do it. (Mental health sector)*
>
> *So kind of reviewing some of those existing processes and making sure that there's, you know, some advocacy and some, some opportunity for to be able to see the whole perspective. (Mental health sector)*
>
> *Yeah. And I talked earlier about, you know, we want to have want to make sure that it's culturally safe that process, we want to make sure that the family are part of that process. And we want to make it safe for families, because sometimes families actually, they want somebody to continue the treatment. So how do we balance out what for no one with what the individual wants? So So, but but we'd like you to do better if we if we get, you know, more people involved in doing this and get the right people? (Mental health sector)*
>
> *Might just like to support that and I think that that idea that the advocacy is really important and that could come from disabled people's organisations or something like Autism New Zealand because I know that perspective is not you know, is not really incorporated at the moment. (Mental health sector)*
>
> *And I just, I also have just in my experience supporting the families of people, even families are not, you know, they are cut out of the process. (Mental health sector)*
>
> *I think one of the ways we'll be around, you know, I think I'm pretty sure you guys are doing it already around regular reviews of CTAs. And, you know, and perhaps sending it on to like a governance group or something for reviews in within organizations. That's probably how it can be protected, people's rights can be protected and*

> *monitored and having those kind of lived experience people on the on the top on the board of these governance bodies, you know, or in groups of them would help the other higher level have to ensure that the people's rights are protected and monitored. (Mental health sector)*

> *Finding some way to ensure patient has support and someone to advocate for them. Like Section 16 hearings can be quite intimidating for the patient and often they are not in the best state to articulate and advocate for themselves. There needs to some way of supporting them and having someone advocate for them, aside from a lawyer. (Duly Authorised Officer)*

> *There needs to be whānau support, some way of helping the whānau understand what is going to happening, what options are, what clinical staff are going to say, and that they understand their rights as well. To make the process more open and that whānau are better informed. It would make it less intimidating or overwhelming. (Duly Authorised Officer)*

Notably, the mental health sector acknowledged provisions within the Mental Health Act that family and whānau should be consulted. However, we heard concerns that such consultation is not regarded as pivotal and often manifests as a “compliance exercise” and is not regarded as a foundational requirement.

> *It's a tricky one, I can't I kind of think there needs to be a level of independence. For support and review, I think, whānau need to be brought in. The current legislation says we must consult with whānau. But I personally feel that it's become a compliance exercise, one phone call, nobody answered, we won't call again. So there's some more measures and to check on on by some safety factors. Also, I think people that may challenge this legal status can quite often be beaten down as this is part of your illness or you know, so it can be quite a damaging, traumatic thing to even challenge without support. So I kind of think in Independence in some way and what that kind of looks like. Yep, that's nice. Certainly following legislation around people that need to be consulted, particularly. (Mental health sector)*

Sector participants acknowledged that tāngata whaiora need to determine who is present at such reviews, as it cannot be assumed that toxicity does not exist within the whānau. In this regard we heard f that tāngata whaiora should determine who attends review meetings. We heard this aspect of tino rangatiratanga should be reflected in the legislation alongside the assurance that opportunities have been afforded for tāngata whaiora to define who they regard as their significant other or have access to independent advocacy.

> *So clearly hated it, because you're right at the moment, it's family whānau, I certainly must be consulted. But what I heard from you is that they need to be actively involved, that don't clear language about making it a nice to, again, a nice to have and actually, and looked at family whānau can also be a challenge. So there'll be some that a*

> *person wants to be involved or not, but about hopefully being able to look at how we do that in a way that is making that person's needs.(Mental health sector)*

District Inspectors

Duly Authorised Officers and some members of the wider mental health sector suggested the individual's rights can be maintained by a continued reliance on district inspectors but involving the district inspectors earlier in the process. We also heard that district inspector involvement needs to be more specified than simply relying on the individual having had some form of communication of their rights. As the following quote documents, at the time of admission some individuals are not believed to have understood the rights that were communicated to them.

> *We could probably involve the district inspectors a lot earlier than what we do. , whether they choose to ring them or not, as then, you know, their choice … that I don't think I think maybe I've been asked for a DIS phone number once or twice, I wouldn't be very, very often. And, you know, I'm not sure that that's ever spoken about, again, after admission, sometimes I'll document, you know, that we don't believe that they understand the process. So I think we should probably be proactively giving them their information and involving them much earlier than what we are involving them earlier. (Mental health sector)*

Within this context Duly Authorised Officers suggested extending protections to include cultural stakeholders. However the role of cultural stakeholders was not articulated.

> *You know, I suppose, you know, we have we have really good access to district inspectors here and we have quite a good relationship with them. And they're always quite readily available. And I suppose they are the obvious people really. The other thing that comes to mind is, you know, culturally, and how well are we protecting people's rights from their perspective. And, you know, I do wonder whether there's a space for you to kind of cultural roles somehow within the Act. (Mental health sector)*

Duly Authorised Officers suggested that provision for advocates should be made during section hearings. Such advocates could include whānau, support peoples, lawyers, independent peer advocates, cultural advisors and kaiawhina.

> *Yeah, look, I think probably just finding some way to ensure that the patient has support and someone maybe to advocate for them. I mean, I'm thinking in particular, I haven't been to many for a few years now. But section hearings, in particular sections, 16 years, I can imagine it feeling quite intimidating for for service users, you know, lined up in front of the judge with the nurse and the doctor on one side of security guard. And that's what we have at Counties. And often they're not in the best state to really articulate and advocate for themselves very well. So maybe if there was some way of promoting or making whānau, or some kind of them having some kind of support or person to advocate for them would be….. they have a lawyer, of course, but someone else that could be a good thing. (Mental health sector)*

Police

Sector participants related that the Mental Health Act can be misused and can remove an individual rights. As such we heard that it vital that the way the individual is engaged is essential and that all efforts need to be made to ensure the individual's mana is maintained while avoiding (re)traumatising the individual.

> *The Mental Health Act as it stands is one of the easiest pieces of legislations to strip somebody freedoms away. The police don't even have legislation that can do that easily. (Mental health sector)*

Participants described that police are often the first responders when someone becomes acutely unwell, and that the way police respond to the individual can escalate an already delicate situation and "they are pretty much bringing a person to hospital who was already very escalated and it just gets worse".

> *Many times, I think police are called in when somebody is violent and agitated in the community. So, from a mana enhancing point of view, it's quite a low point for a whānau members and for a patient. So police need to have some kind of a humanistic role. Because yeah, because if the if they're not, if they don't have that humanistic side, you pretty much bringing a person to hospital who was already very escalated. And that's not going to help again and you know, so it just goes up gets worse. (Mental health sector)*

> *Yeah, so yeah, it can be incredibly traumatic for the person and it find out if they have to call call the place and depending, again, yes practice of how well the place manage that, what time they have. So there are definitely some some issues in there but often it is about the place can transport someone to place to a safe place. (Mental health sector)*

In response, we heard that there is an opportunity for police to adopt a different model of policing in response to mental health concerns. However, no consensus was reached surrounding what this new type of policing might entail. Rather, some from the mental health sector discussed the need for the police to adopt a more "humanistic role". Others discussed the need for specialist police trained in mental health responsiveness while others suggested police should respond to mental health crises in collaboration with Māori wardens or other non-police roles.

> *Maybe there's a role for, for police within the legislation itself, maybe it's a different type of policing, maybe it's a mental health first aid approach to something that's happening in the community that they're able to assess, you know, safety and as a complete life, you know, different, completely different model of policing. Like we used to have community police or police in the schools. Now, maybe it's a completely different model of policing, it's supported by the legislation, it's very good idea. Like, it's like in a police car, maybe one can be a police person and the other can be a Māori*

> *warden, you know, and they attend these kind of calls. So they get cultural safety in this kind of things as well. (Mental health sector)*

We heard that humanistic policing could include dedicated uniforms to distinguish officers specialising in mental health from general policing. Participants suggested that this, coupled with appropriate training, would minimise the risk of escalation. We heard of the opportunity to respond to mental health crises with peer advocates and specialist nurses. Participants suggested that a more holistic crisis response needs to be explored in-depth and that the identification of a best practice model should be embedded in legislation.

> *Especially the police uniform, you know, if you're, if you're going to get a mental health person who's distressed, and was just looking at the police uniform itself, I don't know how that affects them. In terms of trauma informed care, the police are quite well trained on communication, different various groups, and particularly around people that are intoxicated, they had some really good training around how you communicate with some of these intoxicated, I think, potentially, some people on methamphetamine, maybe to I don't know, it's all a bit of an unknown methamphetamine, I think, still at the moment and how we work with people who are intoxicated by meth. Maybe they are part of the police are part of the solution. Maybe they do have more time to sit and talk and I love it love. (Mental health sector)*

> *Being creative and visionary. There is also a police liaison with our peers and clinicians, and it's pilot happening and one of the DHBs to try and actually also look at some peers in there as well. So there's definitely people that are open to being more creative in general and mental health. But yeah, I think it is that what are what is the role and and how, how could that be different so that it's a proactive thing for all involved. (Mental health sector)*

> *But I think there is a real role for community agencies police included to be part of the solution. (Mental health sector)*

> *I have seen the best police work when it's not in a crisis situation. So if we've had patients that repeatedly present after hours, when they build up a relationship with certain police officers and those police officers are the ones that come to them in a crisis situation when they're on duty. But the go-to is the police are called in a crisis. You can have the most well meaning police person, but I think it's just the uniform and the idea that "I'm unwell now and the police have come to my house to drag me away to the inpatient unit". It's that whole mentality that needs to change. (Psychiatrist)*

Special and restricted patients

The term 'special patient' refers to mentally ill offenders detained under specific legislative provisions.

It is important that the special and restricted patients are included in discussions around the Mental Health Act and any future changes. We heard that this is a challenging area.

Forensic services and prison representatives reported increases in tāngata whaiora receiving a custodial sentence yet we heard it is common for these tāngata whaiora not to receive treatment or support. There was a sense that special and restricted patients have the same rights to person-centred health care as all tāngata whaiora. We heard these tāngata whaiora are entitled to better planning, holistic service provision and transparent reviews. Within this context we heard there is an urgent need to ensure the rights of special and restricted patients have their rights are being protected.

> *Do we need special patients status then yes, undoubtedly, in my view. And I'm sure that's a view shared by most of the western world because most of the western world has got us some states or other exactly like it. But should we enact it the way that we currently enact that? Probably no. I personally think that we should move much more to a system like some of the Australian states where we have a board determination as particularly around changes and status, we have a board determination, that'll be like coming out with MH Review tribunal more, because I think that that process around some of the changes and leave and I'm sure, John, you would love this to happen, because it would be a whole lot less work for you. But that where the consideration around a lot of those things were taken out of the hands of the Minister , made much less political, where I think there is the capacity for them to be much more consistently made, much more clinically informed, and actually much more reasonable. (Psychiatrist)*

APPENDIX 5: ORGANISATIONS WHO PROVIDED A WRITTEN SUBMISSION

Aotearoa New Zealand Association of Social Services
Asian Family Services
Auckland University of Technology (law lecturers, students, and researchers)
Australasian College for Emergency Medicine
Autism New Zealand
Autism Wairarapa Charitable Trust
Awareness Members Network
Canterbury District Health Board Specialist Mental Health Services Clinical Directors Group
Canterbury District Health Board Specialty Mental Health Services Restraint Minimisation Committee
CCS Disability Action
Changing Minds
Citizens Commission on Human Rights NZ
DRIVE Consumer Direction, Ember Korowai Takitini
Eating Disorders Association of New Zealand
Eating Disorders Carer Support New Zealand
Hāpai Te Hauora
Health Quality & Safety Commission New Zealand
Human Rights Commission
Life Matters Suicide Prevention Trust
Mahitahi Trust
Mātanga Mauri Ora
Mental Health, Addictions and Intellectual Disability Directorate, Southern District Health Board

Mental Health, Addictions and Intellectual Disability Service, Capital and Coast, Hutt Valley and Wairarapa District Health Boards
Mental Health Foundation
Mental Health Nurses Section of the New Zealand Nurses Organisation
Mental Health Wellbeing Commission
Mind and Body
National Association of Mental Health Consumer Advisors
New Zealand College of Clinical Psychologists
New Council of Christian Social Services
New Zealand Council of Women of New Zealand
New Zealand Drug Foundation
New Zealand Forensic Psychiatry Advisory Group
New Zealand Law Society
New Zealand Medical Association
New Zealand Psychological Society
New Zealand Public Service Association
Nga Hau e Wha
Nōku Te Ao. Like Minds[7]
Office of the Children's Commissioner
Office of the Ombudsman
Office of the Chief Justice
Otago Mental Health Support Trust

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[7] Nōku Te Ao submission was a Position Statement – at the date it was submitted to the Ministry of Health, 846 people signed the Position Statement, almost half identified as Māori or Pasifika.

Otago University Restricted Patient Research Group
Platform Charitable Trust
Office of the Privacy Commissioner
Refugees as Survivors New Zealand
Royal New Zealand College of General Practitioners
Social Service Providers Aotearoa
Take Notice Limited
Te Ao Māramatanga. New Zealand College of Mental Health Nurses
Te Awhi Charitable Trust Tū Whānau
Te Kete Pounamu
Te Mana Karereā (within Northland District Health Board)
Te ManawaTaki. Mental Health and Addiction Wellbeing Regional Network
Te Ohu Rata o Aotearoa. Maori Medical Health Practitioners Association Inc
Te Pou
Te Pūtahitanga Te Waipounamu
Te Runanga of Kirkiriroa
Te Whakakitenga o Waikato Incorporated
The Royal Australian and New Zealand College of Psychiatrists
Thriving Madly
Turning Point Trust and Bay of Plenty District Health Board Mental Health and Addiction Services Consumer Consultant Group
Waitematā District Health Board, Regional Forensic Psychiatry Services
Whakatōhea Social and Health Services
Victim Support
Yellow Brick Road