Mental Health and Wellbeing Commission submission on the Ministry of Health Discussion Document Transforming our Mental Health Law

Introduction

The Mental Health and Wellbeing Commission was established in February 2021 as an independent Crown entity to contribute to better and equitable wellbeing outcomes for people in Aotearoa New Zealand. We provide system-level leadership and oversight, and advocate for the collective interests of people who experience mental distress, addiction (or both), and the people and whānau who support them.

Transforming our mental health law is a once-in-a-generation opportunity. We urge the Government to be bold in creating change that is grounded in Te Tiriti o Waitangi,[1] builds space for healing, and ends human rights violations evident under our current outdated law.

We have focussed our submission on the principles and building blocks for legislative change rather than responding to every question. We expect continued opportunities to shape the detail of legislative and system reform as this work progresses.

We recognise and affirm the Ministry of Health (the Ministry) engaging lived experience experts to seek the voices of lived experience of the **Mental Health (Compulsory Assessment and Treatment) Act 1992** (Mental Health Act) during this submission process. However, the tight timeframes for such a complex piece of work, over the holiday period, and with COVID-19 restrictions in place has impacted the opportunity for a broader participation by whānau, hapū, iwi, people with lived experience of the Mental Health Act and mental health and addiction sector providers.

[1] We recognise Te Tiriti o Waitangi as our nation's founding document, and its status internationally alongside the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Where we refer to Te Tiriti o Waitangi in this document, indigenous rights under UNDRIP are also implied.

The Ministry must build in sustainable co-design processes with Māori and tāngata whaiora[2], privileging the voices of people with lived experience of the Mental Health Act, including their family and whānau, during the next phases of this important mahi. Populations most impacted by the Mental Health Act must be involved, including all cultures, family and whānau, children and youth, disabled people, and tāngata whaiora interacting with the justice system.

Tāngata whaiora, lived experience networks, and the voices that have gone before, including as documented in **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga)** (Government Inquiry into Mental Health and Addiction, 2018), have informed our response to **Transforming our Mental Health Law**. We would like to thank everyone who has engaged with us.

Summary of submission

We recommend that new legislation be grounded in Te Tiriti o Waitangi, maximise tāngata whaiora autonomy, and uphold human rights and equity. New legislation must:

1. explicitly give effect to Te Tiriti o Waitangi in all processes
2. be underpinned by a transformed mental health and addiction system that is responsive and accessible early in the course of increasing distress or 'crisis' and provides genuine choice of services and supports for tāngata whaiora, including alternatives to acute inpatient admission and adequate support for whānau. A transformed system will:
    - 2.1. be responsive and accessible and provide genuine choice of services and supports
    - 2.2. embrace individual and collectivist worldviews, and work to the principles of whānau ora and **Supporting Parents, Healthy Children**
    - 2.3. understand safety from tāngata whaiora perspectives.
3. maximise tāngata whaiora autonomy and protect the human rights of tāngata whaiora on an equal basis with other people, including:
    - 3.1. upholding treatment decisions made by tāngata whaiora
    - 3.2. providing for supports to tāngata whaiora to make decisions about treatment where needed
    - 3.3. having a high threshold for substituted decision-making (compulsory treatment) where tāngata whaiora are unable to make or communicate treatment decisions for themselves, even with support

[2] Tāngata whaiora – is used to emphasise 'whaiora' the desire to 'seek wellness'. The plural tāngata encompasses the individual and the people they determine as their whānau.

3.4. have protections where substituted decision-making is used, including to:
   a) prohibit the use of solitary confinement (seclusion)
   b) minimise restrictive practice with a view to eliminating, and require consistent national reporting, oversight and review
   c) have specific protections for assessment, treatment, review, monitoring and oversight.

4. be co-designed with Māori and people with lived experience of the Mental Health Act. This includes the development of advice to Cabinet, legislative drafting, and wider system reform. Legislative and system reform must have clear implementation timeframes.

1. Te Tiriti o Waitangi is central to transforming mental health law

> "Te Tiriti o Waitangi must be at the heart of all solutions relating to mental health and addiction." (Government Inquiry into Mental Health and Addiction, 2018)

Te Tiriti o Waitangi must underpin a transformed mental health and addiction system and be explicit in any legislation that replaces the Mental Health Act. Te Tiriti o Waitangi upholds the rights:

- of Māori to be Māori, and to exercise tino rangatiratanga;
- to equity in how Māori as tāngata whenua and tāngata Tiriti (non-Māori) are treated before the law;
- for all people in Aotearoa to be treated equitably and have their human rights upheld;
- of tāngata whaiora to access mātauranga Māori, clinical, and cultural Māori expertise, and whānau Māori perspectives;
- of Māori to have wairuatanga acknowledged as a key contributor to mental wellbeing and inclusiveness.

Systemic racism and cultural bias have resulted in persistently higher application of the Mental Health Act to tāngata whaiora Māori. In 2020, Māori were 4.1 times more likely than non-Māori (excluding Pacific peoples) to be subject to a community treatment order and 3.5 times more likely to be subject to an inpatient treatment order. Māori were also 5.4 times more likely to be secluded in adult inpatient services than non-Māori (Ministry of Health, 2021b).

The current Mental Health Act does not formally acknowledge, or adequately represent, or support te ao Māori or Te Tiriti o Waitangi in legislation or in practice. We believe that:

- Māori must have the authority to self-determine responses in times of distress;
- cultural and tāngata whaiora expertise must direct how the system responds, including clinical responses;
- experiences of trauma, distress, and crisis for Māori need to be considered through a Māori lens;
- cultural assessments must be treated as equally valid to clinical assessments and inform decision making accordingly.

We recommend that mental health and addiction system transformation must:

- prioritise and fund access to mātauranga Māori healing and treatment options that reflect whānau, hapū, and iwi aspirations, including for crisis and acute mental distress support;
- enable and fund access to rongoā Māori as well as iwi approaches to mental health, addiction, and wellbeing service delivery;
- require that all mental health, addiction, and wellbeing services are culturally safe and acknowledge wairuatanga as a key contributor to mental wellbeing.

We recommend that new legislation that replaces the Mental Health Act must:

- describe explicitly the actions required to give effect to Te Tiriti o Waitangi in use of the legislation, including specific reference to the Articles and the principles of active protection, partnership, tino rangatiratanga, options, and equity;
- align with the **Pae Ora – Healthy Futures** legislation and the Ministry of Health's **Te Tiriti o Waitangi Framework** described in **Whakamaua Māori Health Action Plan 2020–2025;**
- provide for maximum autonomy by supporting tāngata whaiora to make treatment decisions that reflect their needs, aspirations, and cultural context;
- provide for culturally safe assessments, decisions, and review for tāngata whaiora with impaired decision-making skills;
- require mana-enhancing and mana-protecting practice (see Huriwai & Baker, 2016) including that the tapu space of tāngata whaiora in distress is understood;
- prohibit solitary confinement (seclusion) and minimise the use of all other restrictive practices, including use of 'open low stimulus environments' and 'retreats' that are experienced as coercive (see further recommendations in 3.4).

2. Legislative transformation must be underpinned by system transformation

> "The principles of mental healthcare will change as it loses its coercive interventions and therefore its function as an agent of social control. At the same time, supportive practice will develop and broaden across the whole interface of psychiatry and law enforcement." (Zinkler & von Peter, 2019)

We are seeking legislative transformation that maximises tāngata whaiora autonomy, is grounded in Te Tiriti o Waitangi, and upholds Human Rights and equity. In section 3 we recommend new legislation uphold tāngata whaiora decisions about treatment; support tāngata whaiora decision-making; and has protections in place for when tāngata whaiora are unable to make decisions for themselves. For such legislative transformation to be successful, it must be underpinned by mental health and addiction system transformation that goes beyond activities already underway.

System transformation needs to occur across a continuum of support, as envisaged by **Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing** (Ministry of Health, 2021a), and address systemic racism and the social determinants that contribute to mental distress. The current use of compulsion reflects a failure of the system to provide timely and appropriate supports that are acceptable to tāngata whaiora. We have been told by tāngata whaiora and whānau that they often feel like the Mental Health Act is used to facilitate access to the support they need.

2.1 A transformed system must be responsive and accessible and provide genuine choice of services and supports

In order to maximise tāngata whaiora autonomy in times of significant distress, the mental health and addiction system must meet tāngata whaiora where they are; understand their experiences, needs and aspirations; and respond through whanaungatanga and mutuality with genuine choice of services and supports.

Tāngata whaiora must have wellness resources and supports that reflect what they need and want in ways that provide equitable access and outcomes. Medication-free responses to significant distress should be recognised and validated.In the Commission's engagement with tāngata whaiora we heard that an ideal system response to significant distress would include:

- easy access to short-term therapeutic spaces that are culturally and age-appropriate, welcoming, and hopeful;
- warm, caring peer, clinical, or non-clinical people who will listen;
- the availability of specialist peer workers;

- tikanga-informed approaches e.g. karakia, wānanga (open dialogue), hohou i te rongo;
- hei piringa - safe spaces in communities where tāngata whaiora can rest and heal;
- offering healing environments for significant distress that embrace te ao Māori and are peer-led as options alongside acute inpatient admission;
- rongoā Māori and medication choices, including support to not use medication;
- easy access to practical resources that support whānau, whanaungatanga, and mutuality.

Making support truly accessible and valuable to Māori would mean having options to use marae, moana, awa, and other environments as places of healing with tohunga support. In mainstream services it would mean creating an environment where Māori feel safe. This might include providing whānau rooms to allow kōrero to happen in private and putting images of mana whenua, maunga, and awa in places of healing to communicate and connect with people, to help them feel at home, and like they're not alone.

Wellness resources and supports must be responsive and accessible to all cultures and ages and equally available for people accessing services within the criminal justice system. We acknowledge that Ara Poutama Aotearoa – Department of Corrections have undertaken significant work to improve mental health and reintegration services (Azuela, 2018). Work to improve mental health and addiction support in the justice sector must continue as part of the system transformation.

Ensuring mental health and addiction support happens early and expanding choice in times of significant distress will reduce demand for acute inpatient beds and be more responsive to the needs and aspirations of tāngata whaiora. Such transformation requires dedicated planning, funding, workforce development, and implementation support.

We recommend that the **Mental Health and Addiction Annex to the Health Plan** and the **System and Services Framework** set out and resource changes to service provision that will support legislative transformation. Our mental health and addiction system monitoring framework **He Ara Āwhina (Pathways to support),** will provide direction about what an ideal mental health and addiction system should like from a te ao Māori and a shared perspective. The framework is currently under development with an Expert Advisory Group of which the Ministry of Health is a member. We will be seeking public feedback on this framework in March and April 2022.

We recommend that dedicated sector leadership and workforce development is put in place to support the sector to:

- unlearn assumptions and ways of working under the current Mental Health Act; and
- develop new strategies and skills to work in an environment that maximises tāngata whaiora autonomy and operates without the use of force. New strategies and skills could include supervision and training by people with lived experience of mental distress.

We recommend co-designing accountability measures for system transformation and incorporating them as appropriate into legislation and planning and reporting requirements.

2.2 A transformed system must embrace individual and collectivist worldviews

A transformed mental health and addiction system needs to work for all cultures and enable the experiences, needs, and aspirations of tāngata whaiora to be understood in a variety of ways, including:

- a te ao Māori understanding of whānau that encompasses hapū and iwi and ways-of-being are that drawn from taonga tuku iho (ancestral knowledge);
- an individualistic view of people as separate beings with independent rights as described in **The New Zealand Bill of Rights Act (NZBORA)**, the **Code of Health and Disability Services Consumers' Rights**, and United Nations human rights instruments.

Much of New Zealand's legislation and policy takes an individualised approach to privacy, responsibility, and health. This needs to change so that the system can operate effectively in this environment, while enabling collective decisions and shared responsibility. Tāngata whaiora need to be able to exercise their right to bring their people with them into a process of seeking and engaging with support.

We recommend the system works to enable whānau engagement, using the **Whanau Ora Outcomes Framework** (Te Puni Kōkiri, 2016) and the guidelines of **Supporting Parents, Healthy Children** (Ministry of Health, 2015) and actively protects tāngata whaiora with parental responsibilities from discrimination related to mental distress.

We recommend the Ministry draws on the Department of Prime Minister and Cabinet's policy improvement framework as a potential way to incorporate these worldviews, as well as the Law Commission's (Te Aka Matua o te Ture - Law Commission, 2021) work to review adult decision-making capacity law, which

includes consideration of te ao Māori perspectives on decision-making capacity and its regulation.

2.3 A transformed system must understand safety from tāngata whaiora perspectives

A transformed system needs to shift understandings of crisis and safety from clinical risk-management to mutual support and shared responsibility. Such a shift would enable tāngata whaiora experiences of crisis and distress to be understood as personal and social in nature. Evidence shows that clinical assessment of risk is unreliable as a predictive tool while collaborative and tāngata whaiora-led safety plans improve safety and health outcomes (Mead & Hilton, 2003; D'Isselt, 2013).

When crisis is understood as being personal and social in nature, rather than a medical emergency, new responses become possible (Minkowitz, 2019). By responding to crisis as a personal and social matter, the support system would focus on identifying and resolving the situation that has become a crisis in the person's life, rather than attempting to contain or medicate the person. A transformed system would provide support to:

- make decisions regarding the situation of crisis;
- maintain tāngata whaiora and others' safety; and
- resolve conflicts or deal with legal matters.

Legislation should ensure that all steps are taken to enable tāngata whaiora to retain autonomy to lead their wellbeing and recovery. Tāngata whaiora wisdoms, goals, and aspirations need to be central to decision-making with solutions collaboratively sought through whanaungatanga and mutuality.

A mutual support approach to understanding crisis and safety should also be applied for tāngata whaiora who are at risk of being drawn into, or are currently within, the criminal justice system. The role of Police in responding to people experiencing mental distress should be reviewed as part of this co-designed transformation. The focus of crisis responses needs to be on supporting tāngata whaiora to resolve the crisis by offering support options without coercion.

We recommend a coordinated approach to facilitate a national conversation to reconsider beliefs, evidence, and attitudes about mental health and risk, to encourage greater community acceptance and support of people in distress as recommended in **He Ara Oranga**. We note there have been some discussions across the sector already that can be built on. Lived experience leadership must be central in this work.

We recommend new standards, accountability measures, and professional development to embed best practice. The current **Guidelines for Clinical Risk**

Assessment and Management in Mental Health Services (1998) urgently need to be replaced to embed evidence-based practices. These practices would facilitate power sharing and tāngata whaiora-led decision-making, whilst also recognising and enabling te ao Māori, tikanga Māori, te reo Māori and mātauranga Māori ways of healing and practicing.

3. New legislation must protect the rights of tāngata whaiora on an equal basis with other people

> "To be banished from humanity – seen as unworthy of belonging and confined in seclusion– is deeply damaging to the human soul. Forced treatment – including forced medication and forced electro convulsive treatment, as well as forced institutionalisation and segregation – should no longer be practiced … Segregation is harmful – not only for the individual, but also for the community as a whole." (UNHCR, 2018)

We recognise the harm tāngata whaiora experience under the Mental Health Act. Compulsory assessment and treatment diminishes autonomy, is stigmatising, restricts movement and travel, can make it difficult to maintain or gain employment or housing, and separates tāngata whaiora from whānau.

For many people, entry into compulsory treatment is forceful and traumatising and opens up the possibility of being restrained, medicated against their will, and secluded. For Māori, inequitable use of compulsion and coercion can only be understood in the context of colonisation and systemic racism.

Aotearoa has obligations under domestic and international law that are not being upheld by the current Mental Health Act.[3] Rights in domestic and international law overridden by the Mental Health Act include the right to autonomy and to refuse medical treatment; and for disabled people to have equal treatment before the law, freedom of movement, and to be free from cruel and degrading treatment.

Outside of the Mental Health Act, people accessing health and disability services have the right to make an informed choice and give informed consent to the extent, appropriate to their decision-making skills. Medical services can only be provided

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[3] Especially **Te Tiriti o Waitangi** and the: **New Zealand Bill of Rights Act 1990**; **Code of Health and Disability Services Consumers' Rights**; **Declaration on the Rights of Indigenous Peoples**; **Convention on the Rights of Persons with Disabilities**; **Convention on the Rights of the Child**; and the **Optional Protocol on the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**. See ***Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992*** (Ministry of Health, 2020) for a description of rights relevant to compulsory treatment.

without consent in limited circumstances, including that when a person's decision-making skills are impaired, reasonable steps have been taken to ascertain the person's views, and the services provided are in the person's best interests.[4]

The current Mental Health Act is discriminatory and stigmatising on the basis that a person must have a "mental disorder" to be subject to its powers; pose a "serious danger" to themselves, or others; or have seriously diminished capacity to care for themselves (section 2).

The current Mental Health Act does not distinguish whether tāngata whaiora:

- are able to make decisions about their treatment and give informed consent
- need support to make decisions about their treatment and express preferences or give informed consent
- have impaired decision-making skills (whether temporarily or longer term) and are unable to express preferences or give informed consent.

We believe that law based on decision-making skills,[5] and that does not discriminate on the basis of psychiatric diagnosis, will provide the best protection for the human rights and mental health and wellbeing of tāngata whaiora in Aotearoa.

We recommend 'mental disorder', or mental distress of any kind is not used as a basis for compulsory treatment. Linking unconsented treatment to decision-making skills rather than mental health status enables new legislation to meet our international human rights obligations and gives tāngata whaiora the same right to refuse medical treatment as other people in Aotearoa.

We recommend best practice for assessment is guided by processes that honour manaakitanga and whanaungatanga and provide the time and safe spaces for tāngata whaiora to determine their health plan and who will be involved in that process.

3.1 Decisions made by tāngata whaiora should be upheld

As well as being a fundamental human right, autonomy to make decisions about treatment is crucial to tāngata whaiora wellbeing and recovery. Tāngata whaiora, including tamariki and rangatahi, should be assumed to have the skills to make decisions about their treatment unless there is evidence that their decision-making

[4] Right 7(4), **Health and Disability Services Consumers' Code of Rights**.
[5] We are using the term decision-making skills to describe the concept of 'mental capacity' as it descibes the functions that mental capacity assessments test for. 'Mental capacity' is a concept used in health and other law and is currently being reviewed by the Law Commission - Te Aka Matua o te Ture.

skills are impaired. Services need to take time to hear what people want and do their best to make it happen, negotiate, and explore all possible solutions. A transformed system must have flexible options to support tāngata whaiora to determine solutions, particularly when a treatment offered is declined against the advice of clinicians.

We recommend that:

- the right of tāngata whaiora to make decisions about the treatment and support they receive should not be overridden by new legislation
- new legislation should require services to offer other options alongside acute inpatient admission. Services must be responsible for providing options, negotiating supports, and working alongside tāngata whaiora to find environments where tāngata whaiora feel safe and are free from force
- new legislation should apply the same criteria to 'special patients' as a first principle, with a subsequent consideration of any changes needed to support the safety of tāngata whaiora and whānau.

3.2 Tāngata whaiora should be supported to make their own decisions

> "Ensure disabled people and their representative organisations have sustainable resources to lead the development of supported decision-making capability for disabled people, whānau, and duty bearers such as the health and disability workforce, legal profession, and financial institutions"
> (Independent Monitoring Mechanism, 2019)

Where needed, new legislation must provide for tāngata whaiora to be supported immediately, to make decisions to their fullest capacity about the support they receive, and to give informed consent.

Under current New Zealand law, a person is considered to have decision-making skills (mental capacity) when they can: understand the information relevant to the task or decision involved; retain that information; use it to decide; and communicate their decision (Dawson, 2015). This capacity can be improved with active support to achieve each of the steps required, rather than passively observing whether the steps are achieved.

Supported decision-making includes but is not limited to:

- providing time and space to find out what is going to work for tāngata whaiora
- ensuring te ao Māori and culturally appropriate processes
- communicating information in ways that tāngata whaiora can understand it and use it, including information and support in their first language

- exploring options including mātauranga Māori
- recognising the value of collaborative decision making to assess and support tāngata whaiora to understand options and find solutions through kōrero (wānanga / discussion / open dialogue)
- supporting the development of advance directives and safety plans and ensuring they are followed in times of significant distress
- having independent advocates who are trained in supported decision-making.

Advance Directives and care plans can form a part of a person's supported decision-making, by providing - at another time - a reference point of their views on how best to support them during times of significant distress. The **Code of Health and Disability Services Consumers' Rights** recognises the right to use Advance Directives. However, they are often ignored or not referred to in the circumstances they were intended for, and are not binding with regard to compulsory treatment under the current Mental Health Act.

We recommend that in every situation where tāngata whaiora decision-making skills are impaired, tāngata whaiora should be supported to make decisions to their full ability. New legislation should state minimum requirements for supported decision-making, including cultural support. The workforce will need training and professional supervision to make these new requirements effective in practice.

We recommend new legislation should support collaborative care plans being developed, ensure that advance directives are followed, and require a procedure for them to be updated if the will and preferences of the owner have changed.

We recommend that new legislation requires independent Peer Advocates be made available. Feedback from people with lived experience tells us that independent, trained advocates who have lived experience of mental distress are preferred and should have access rights in line with those of District Inspectors. The Independent Monitoring Mechanism responsible for overseeing New Zealand's compliance with the UNCRPD suggests that peer-led organisations should have a role in developing decision-support networks and training Peer Advocates. Workforce development to facilitate supported decision-making during times of significant distress will also be required.

We recommend the Ministry take note of the Law Commission's (Te Aka Matua o te Ture - Law Commission, 2021) consideration of the role of supported decision-making in enabling people to make their own decisions, including what support is appropriate and how people are safeguarded from harm, as part of its review of adult decision-making capacity law.

3.3 Decisions should only be made for tāngata whaiora as a last resort

Where tāngata whaiora have impaired decision-making skills and are unable to communicate their preferences, new legislation should set a high threshold for when substituted decision-making can be used.

We recommend substitute decision-making should only be permitted in new legislation, when all of the following have been satisfied:

- the person is unable to make or communicate decisions even with support
- significant safety concerns for tāngata whaiora or for others have been identified
- all other options to address safety concerns have been exhausted
- the decision reflects tāngata whaiora experiences, needs, and aspirations (will and preferences)
- any removal of tāngata whaiora autonomy or freedom is in proportion to the safety concerns, minimises harm, and improves safety.

We recommend that where the decision-making skills of tāngata whaiora are thought to be impaired:

- assessment must include appropriate whānau, peer specialist, and cultural support as determined in collaboration with tāngata whaiora; and
- best practice for assessment is guided by processes that honour manaakitanga and whanaungatanga, to provide the time and safe spaces for tāngata whaiora to determine their health plan and who will be involved in that process.

We recommend the duration of substitute decision-making should be short-term and limited to the duration that decision-making skills are impaired. Substituted decisions must specify a short-term review period and criteria for revoking the impairment assessment.

3.4 Protections are needed where tāngata whaiora cannot make decisions

In a transformed system, where decisions are made for tāngata whaiora, substituted decisions (compulsory treatment) should still be made free from force and in an environment where tāngata whaiora feel safe. Protections are nonetheless needed in legislation to ensure the wellbeing of tāngata whaiora and to minimise the potential for harm and limitation of rights.

Legislation that uses decision-making skills as the basis for determining the need for substituted decision-making will need to be supported with legislated protections and national monitoring and practice improvement processes to eliminate biases.

Such biases include the influence of systemic racism, ableism, and unconscious bias when applied in practice.

Solitary confinement must end

Solitary confinement has no therapeutic value and can cause significant, lasting psychological harm, particularly for people with pre-existing mental distress or childhood trauma. Such harm is magnified by longer periods of confinement, can be long lasting, and is associated with increased risks of self-harm and suicide (James & Vanko, 2021).

Independent bodies ranging from the UN Subcommittee on the Prevention of Torture, the Independent Monitoring Mechanism for the UNCRPD (Independent Monitoring Mechanism, 2020), and the Human Rights Commission (Shalev, 2020) have each recommended that the practise of solitary confinement, particularly in psychiatric settings, be eliminated.

We recommend that future legislation prohibits solitary confinement[6] (seclusion) in all mental health services (including National Forensic Facilities). Services have been supported to achieve zero seclusion through the Health Quality and Safety Commission (HQSC) quality improvement programme and will have adequate time to prepare for new legislation.

We recommend that the Ministry considers an interim measure, until legislation is in place to prohibit solitary confinement, that solitary confinement be classified under the HQSC's Adverse Event reporting framework, to encourage elimination and to support the transition to prohibition of solitary confinement.

Restrictive practices are a system failure that must be minimised with a view to elimination

Restrictive practices make tāngata whaiora do something they do not want to do or stop tāngata whaiora from doing something they want to do. Restrictive practices are known to cause trauma and re-traumatisation, distress, fear, feelings of being ignored or controlled, and dehumanising conditions (Cusack et al, 2018). In a transformed mental health system underpinned by Te Tiriti o Waitangi and maximising tāngata whaiora autonomy and human rights, restrictive practice should be viewed as a system failure that must be minimised with a view to eliminating.

[6] We advocate using the term solitary confinement in place of 'seclusion' because it more accurately reflects what people experience when they are locked alone into spaces from which they cannot get out unless another person lets them out. This recommendation is in keeping with the practice of the UN Special Rapporteur on Torture, and Other Cruel, Inhuman, or Degrading Treatment or Punishment.

We support the requirement in the updated Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (Ministry of Health, 2022) that DHB Inpatient services strategic plans are to have an objective that aims to eliminate restraint which is linked to annual planning, commitments to implementing strategies to eliminate restraint, and quality improvement approaches.

We acknowledge there is a wide spectrum of restrictive practice, from locking a unit to chemically or physically restraining someone. **We recommend** restrictive practices be limited to the shortest possible time, using the least restrictive means, and are used **only** where there is imminent risk to self or others.

We recommend that consistent national monitoring, reporting and review of restrictive practices be co-designed and align with the HQSC National Adverse Events Reporting Policy (HQSC, 2017), with a view to minimising and eliminating restrictive practices. Co-design should include: considering whether to prohibit specific restrictive practices such as mechanical and chemical restraints; the introduction of independent reviews of restrictive practice involving tāngata whaiora and cultural support; and quality improvement processes. Specific monitoring and reporting for Māori, Pacific peoples, disabled people, and young people is needed.

Protections are needed for assessment, treatment, review, monitoring and oversight

We recommend protections for the use of substituted decision-making should include:

Assessment

- incorporating te ao Māori perspectives into decision-making skill impairment assessments
- tāngata whaiora determining whānau involvement, and for tāngata whaiora views to be considered where others have a legal right to make decisions for them (e.g. as a legal guardian or because of an enduring power of attorney)
- involving whānau, as determined by tāngata whaiora, as soon as practicable
- supporting tāngata whaiora to regain decision-making skills.

Treatment decisions

- limiting the types of treatments that can be given without consent, and requiring all allowable treatments administered without consent to be reported into a national database
- considering tāngata whaiora views of the effects, including physical, social, economic, emotional, psychological, and spiritual harms when assessing potential harm from treatment
- requiring the physical health needs of tāngata whaiora and effects of medications to be actively monitored and addressed

- ensuring that hospital inpatient settings for tamariki and rangatahi are provided as a last resort. Any inpatient facilities for tamariki and rangatahi should be separate from adults, unless in their best interests. Even within an adult unit there should be separation for young people from adults.

Review

- shorter assessment periods and a shorter substituted decision-making period, compared to the current system, with regular periods of review
- incorporating te ao Māori into reviews of decisions
- having specific protections where decisions have longer-term implications, including independent reviews with psychological, cultural, lived experience, and whānau perspectives.

Monitoring and oversight

- independent monitoring and national reporting of substituted decisions and restrictive practices, with psychological, cultural, peer, and whānau perspectives.

4. System transformation and new legislation must be co-designed with Māori and people with lived experience of the Mental Health Act

> "The requirement for the Crown to partner with Māori in the development and implementation of policy is especially relevant where Māori are expressly seeking an effective role in this process. Further, the requirement for the Crown to partner with Māori is heightened where disparities in outcomes exist."
> (WAI 2575, 2019)

Co-design is essential to enable best practice in a transformed mental health and addiction system and new legislation.

We recommend:

- both the legislation and the transformed system are co-designed with Māori and tāngata whaiora, privileging the voices of people who have lived experience of being placed under the Mental Health Act
- ongoing co-design
- to enable best practice, populations most impacted by the Mental Health Act must be involved, including all cultures, family and whānau, children and youth, disabled people, and tāngata whaiora who interact with the justice

system. Each have particular needs and aspirations that need to be reflected in future legislation and practice.

We recognise that co-design and system transformation takes time and that good processes are needed to ensure progress in a timely manner.

We recommend a phased approach to implementation that sets explicit and timely processes and timeframes for legislation and system changes to be enacted, aligned to the **System and Services Framework** implementation, and supported by a quality improvement approach to practice change.

Thank you for the opportunity to submit on this important mahi and we look forward to continued involvement as this work develops. We are happy to meet with you to discuss the matters we have raised and how we can be involved in the next stages of this process.

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Glossary

These definitions reflect the meanings applied to these words in this document.

aroha	love, concern, compassion, empathy
awa	river
hapū	sub-tribe
hauora	holistic health and wellbeing
hohou te rongo	to make peace
impaired decision-making	when a person is unable to make or communicate decisions even with support
informed consent	self-directed agreement based on a full understanding of all relevant information
iwi	tribal grouping
kaupapa	central purpose, initiative, issue
kāwanatanga	government, governorship mana, prestige, authority, control, power, influence, status
korero	conversation, discussion
kōrerorero	discussion, open dialogue, chat
mana motuhake	autonomy, self-determination, sovereignty, self-government
mana whenua	Māori who have tribal, historical, and territorial rights over the land
manaakitanga	hospitality, kindness, generosity, support - the process of showing respect, generosity, and care for others
mātauranga Māori	the Māori worldview, Māori knowledge, traditional knowledge
maunga	mountain
rangatahi	younger generation, youth

rangatiratanga	chieftainship, authority, right to exercise authority, chiefly autonomy, chiefly authority
rongoā	indigenous medicine and treatment
supported decision-making	a process where people are professionally supported to understand information and make their own decisions
substituted decision-making	decisions being made about tangata whaiora when their decision-making skills are assessed as being impaired
tamariki	children
tāngata whaiora	people seeking wellness – this variation is used to emphasise 'whaiora' the desire to 'seek wellness'. The plural tāngata encompasses the individual and the people they determine as their whānau
tāngata tiriti	people of the treaty, non-Māori citizens
tāngata whenua	people of the land, local people
tapu	sacred, prohibited, restricted
te ao Māori	the Māori world
tikanga	correct procedure / protocol, a system of values and practices
tino rangatiratanga	the fullest expression of rangatiratanga, autonomy, self-determination, sovereignty, self-government
wairuatanga	spirituality
wānanga	open dialogue; to meet and discuss, consider, deliberate
whanaungatanga	a relationship through shared experiences and working together which provides people with a sense of belonging
whānau	family, including people chosen as family
whānau ora	family wellbeing