Transforming Mental Health Law in New Zealand

1. What is your name?
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3. Are you submitting:
This submission supports the position of New Zealand Nurses Organisation kaimahi and members, with feedback provided by members of the College of Emergency Nurses, and College of Mental Health Nurses.

4. What best describes you?
Tōpūtanga Tapuhi Kaitiaki o Aotearoa, New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the development of a Digital Strategy for Aotearoa New Zealand. NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand, representing 54,919 nurses, midwives, students, kaimahi hauora and health workers on professional and employment matters. NZNO embraces te Tiriti o Waitangi and contributes to the improvements of the health status and outcomes of all people of Aotearoa New Zealand through influencing health, employment, and social policy development.

The College of Emergency Nurses and College of Mental Health Nurses support principles that maintain consistency with Te Tiriti o Waitangi to meet Māori cultural needs and rights to self-determine and have active protection. They commend the principle to embed human rights frameworks, maximise independence where inclusion of society results in safety of individuals, whānau and communities. They also stressed the importance to improve equity of care and treatment via recovery approaches. The point was to ensure that timely and accessible services were provided, including options of choice. The emphasis also was placed on ensuring the least restrictive mental health care options was applied. Furthermore, the support the transformation of assuring that the delivery of quality, affordable and timely mental care and treatment relies on a whole system of providers and services operating efficiently and effectively (pp.16, s2.2.4 refers).

We welcome further consultation on the progression of the transformation of Mental Health Law and would like to see specialist nurses from these colleges providing direct feedback, as we anticipate there will be reference groups established.

Ngā mihi

5. What is your ethnicity?
All

6. Which age group do you belong to?
All ages 19 plus

8. Official Information Act responses
We support OIA requirement

9. How can legislation help embed Te Tiriti o Waitangi?
The intention of Te Tiriti o Waitangi (te Tiriti) is to uphold the rights of active protection, for tāngata whenua to exercise their rights to tino rangatiratanga, whereby political autonomy to determine aspirations across all areas of health equity including wider social determinants of health and wellbeing are been equally met by the te Tiriti partner, the Crown.

The unintended consequence in the absence of te Tiriti means inequities continue with increased reports of poor health and wellbeing outcomes for Māori. Decades of evidence affirm the deficit kōrero of Māori poor rates compared to non, including higher rates of poor outcomes experienced across social, education, and justice (page 11 refers). The gap is significant and accompany with the uncertainty the pandemic has exhausted existing structural systems to attempt to improve health and wellness for Māori and all ethnicities. Changes is now and should not happen in isolation of other sectors. Principles of te Tiriti should be overarching and accountability, compliance, regulation, designing, planning, implementing, monitoring, evaluating, should already have taken considerations of te Tiriti values and principles. Indicating that a te ao Māori frame of thinking will be influencing outcomes for Māori, whether whānau/patients at the operations service and delivery end, choose to access kaupapa Māori services or not. The obligation to provide an equitable approach is guaranteed under te Tiriti. Currently, the option to access and apply te ao Māori models of health varies. This should be compulsory, not optional. The choose is in the whānau or patients' ability to choose to participate or not.

10. What kaupapa Māori principles should the legislation incorporate?

The commissioning of kaupapa Māori services developed for Māori in accordance te Tiriti and the principle of active protection. Particularly, as many Māori models of health and traditional practices such as rongoā Māori are and remain heavily scrutinised by public health associations, in terms of western standards of care. Active protection through ensuring intellectual property of matauranga Māori is important and should be protected with incorporating an explicit clause that gives effect for non-Māori seeking to offer kaupapa Māori services that they will need to refer to principles of te Tiriti and ensure that tikanga models of care, can only be led by Māori, with the intention to support whānau Māori in need first. A by Māori for Māori policy regarding standards of care using tikanga Māori values that many iwi/hapū, Marae and community-based health clinics apply. The Wai 2575 refers to the significance of kaupapa Māori services and the impacts of reducing inequities by eliminating stigma and discrimination.

Opportunities such as the governments investment in the Poutama Ora Services based in Taupō and Rotorua that is support a kaupapa Māori primary mental health and addiction service for those experiencing mild to moderate mental distress or addictions issues, seems to reaching a number of communities experiencing hardship. It is the application of traditional methodologies that is important, with pūrākau (mythological traditions) and other tikanga and Kawa practices that have created a safe and protected environment for whānau. This is just one of the government's recently funded kaupapa Māori service. However, the asks are that we provide more opportunities to invest in such treatment services. As we already have many Māori providers already applying such tikanga, however at their own cost and self-directed referral system. The referral process varies with many health professionals may only refer to those government mandated services, or subsequently the court orders only incorporating non-Māori methods of treatment and care.

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

Embedding te Tiriti shifts towards transforming authority and instead inviting action to make meaningful changes to an already broken and oversubscribed sector, the reality is we can no longer operate under the current regime. Change requires an authority that operates under the premise of inclusivity, whereby diversity requires connecting, listening, sharing and learning from cultural, social, environmental needs to best support education on health and also creating healthy outcomes that result from a system that accommodates the inclusivity of an equity approach for all. Particularly for tamariki, and those with disabilities. For Māori who have disabilities the experiences of inequities far out ways non-Māori experiences. Tamariki

our taonga that require the most protection and with change with the mate korona variant from Delta to Omicron, the vulnerability and complexities to protect and care for our young population is urgent and given Māori population is generally more youthful than other populations, considerations of te Tiriti is crucial. Te Tiriti accompany with international legal instruments specific to children/tamariki should be applied to ensure human rights frameworks are being upheld. The following conventions should accompany te Tiriti they include:

- **Declaration on the Rights of Indigenous People**
- **Convention on the Rights of the Child (CRC) (like Sec7AA – Oranga Tamariki Act)**
- **Convention on the Elimination of All Forms of Discrimination Against Women, (CEDAW)**
- **Convention on the Rights of Persons with Disabilities (CRPD),**
- **Convention on the Elimination of All Forms of Racial Discrimination (CERD).**

The gaps in mental services for children and young people still remain with the lack of forensic, residential placements and obviously with the shortage of mental-health professionals who specialise in working with children and young people and a shortage of addiction services for young people and those with parenting responsibilities. While the government is creating vehicles to address inadequate co-ordination among the multiple agencies involved in the care and treatment of young people, the need remains high.

Part 4: Compulsory Treatment
General comments
We support the commentary in discussion document that completely banning compulsory treatment could result in individuals in a vulnerable and distressed state, going untreated or being left to fall into the justice system. The (reasonable) expectation that the public health system protects and provides care for people who are unwell includes when people are unable to make safe selfcare decisions whether this has a temporary organic cause or is an acute psychiatric illness.

Risk assessment of harm to self or others can be complex in an acute emergency and often requires a period for acute management and evaluation.

Capacity assessment is difficult when people are unable to participate in conversation in a meaningful way and when whanau or cultural support resources are not available.

There remains a lack of appropriate facilities and healthcare staff to respond in a timely manner to people presenting with acute mental health assessment concerns and needs, particularly out of weekday daytime hours. Specific mental health clinicians based in emergency departments are a positive way of improving timely specialist assessment.

An increase in community and iwi-based hubs would help provide urgent support as well as ongoing care that would improve the service particularly with complex situations. Access to telephone and online services are also important resources to improve access and support.

Current Covid related precautions increase the difficulty for people to tolerate long waiting times in a busy emergency department environment and can increase anxiety and distress.

Specific questions:

Compulsory mental health treatment should remain a last resort option that is used when a person is a serious risk to themselves or others, e.g. suicide or serious assault. Acute exacerbations of psychosis, depression or mania can lead to actions that result in significant long-term harm?

Mental health condition is a term that carries less prejudice than mental disorder. There may be other terms that are reduce stereotypes more and encourage a wellness recovery approach?

Compulsory mental health treatment should be feasible in both inpatient and community settings to enable a recovery approach and transition from inpatient treatment if this is indicated?

The current process where whanau and health professionals can indicate their concerns which leads to a specialist mental health clinician assessment is a reasonable approach. An emergency process (section 111) is still needed for non-specialist staff or police when an acute crisis is underway and specialist clinicians are not immediately available?

Part 5: Capacity and decision-making

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

In considering acts of criminal harm and inappropriate behaviour there may be caused to refer to some oversight that resembles mandatory requirements to address mental disorder deemed incapable of making coherent and healthy decisions. The Mental Health Act should therefore make clearer provisions when actions applied under the decisions of the criminal justice system defined by the Criminal Procedure (Mentally Impaired Persons) Act 2003. Whereby, people are found unfit or guild on account of insanity, and require combination of criminal imprisonment and treatment, and especially for those requiring psychiatric hospital treatment in a forensic inpatient unit. However, not for those pending trial or sentencing as there has not be a defined outcome established. There should be no compulsory mandatory requirement for those entering mental health system due to having experienced life-threatening circumstance. For instance, family violence, child neglect and abuse, poverty leading to recidivism behaviours. Other means of treatment should be considered, rather than forensic psychiatry services. This where kaupapa Māori services could be applied to support and orient recovery.

Considerations of outcomes of the Mental Health Act, practising psychiatrists should be aligned to other primary legislation that impacts tamariki and whānau relationships with patients who come under the act. The Bill of Rights Act 1990 sets out the fundamental freedoms of all New Zealanders, including the right to life and security of the person. It ensures discrimination is consider and not determining outcomes for treatment. Particularly, those with disabilities and mental illness. This is further supported and strengthened by New Zealand's ratification of the Convention on the Rights of Persons with Disabilities. Further the Privacy Act additionally supports protection of patients' information.

Therefore, compulsory treatment is very evasive and should not be the first option for any order. Dr Diana Kopua, from the Royal Australia New College of Psychiatry, staunchly supports not having compulsory treatment orders. Particularly as many refuse treatments and often are pressured into this decision based on institutional racism, due to lack of professional insight. What should be reviewed is the recovery-oriented environments which remain complex for Māori and other indigenous cultures such as Pacific Peoples. The concerns and tension with compulsory treatment, particularly with the right to refuse and allowing people who are very capable to make informed consents is concerning among professionals. As these orders may not be consistently assessed or necessarily the first option to care and protection. However, care and protection does extend to those working with those experiencing mental illness, there safety is important and should be reviewed with some for of immediate staff safety approach that includes cultural safety standards should be key priority for the Mental Health Act.

Reference
Soosay, I., & Kydd, R. (2016). Mental health law in New Zealand. *BJPsych international*, *13*(2), 43–45. https://doi.org/10.1192/s2056474000001124

23. If decision-making capacity is a criterion, what matters should be relevant to an assessment of whether a person has the capacity for the purposes of mental health legislation?
Ensuring communication is transparent and effectively informing the assessment procedure. Considerations of many factors that include cultural, social, economic interms of environmental and income pressures, including physical health or histories of health should be indicators to determining whether the mental health legislation applied, when seeking informed consent.

24. Who should assess whether a person has the capacity to make a decision about mental health treatment?
Should a whānau centred approach offered if the consent is also given by the patient and or their whānau support.

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

If the safety of kaimahi is threatened their all risks should be averted with a whole of history assessment to be provided to provider of care, prior, even in emergency. Policy and security should be on hand we always transport patients. Obviously, an increase in workforce safety measures and personnel is a must if such orders are to be sanctioned.

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

The criterial of cultural safety standards would apply and be aligned to principles of te Tiriti and mātauranga Māori tikanga and kawa, that Māori models of health provide. For instance, Taina Pohatu Mauri Ora model and of course Sir Mason Durie's Te Whare Tapa Wha, there are many models that Māori providers have applied but have not received the appropriate recognition or acknowledgement of their full potential.

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

Refer to evidence and literature on cultural safety and Māori models of health. Considerations from the newly propose Pae Ora (Healthy Futures) Bill and previous mahi such as He Korowai framework provide indicators of health and equity and lead from principles of tino rangatiratanga, ōritetanga, kotahitanga, Wairuatanga, whanaungatanga.

28. How would the criteria for compulsory mental health treatment affect population groups (for example, children, disabled people, etc)?
Populations most at risk are those underserved communities experiencing multiple complexities of health and social in terms of racism, those with disabilities, economic, and environmental impacts in terms of deprivation and poverty, that is intergenerational. This has only doubled since the pandemic.

General commentary
Incapacity to make decisions and risk to self or others are important criteria relating to compulsory treatment

Specialist mental health clinicians should assess capacity to make decisions regarding mental health treatment if there is a process to address acute safety concerns when those staff are not immediately available.

The criteria regarding risk should include short or long-term impacts and the severity of the impacts.

Cultural and whanau support, and independent advocacy are important resources to enable the least restrictive approach to treatment and ensure a person(s) best interests are maximized.

The ability to communicate effectively is an important part of the assessment process therefore those who have challenges with communication such as age, disability, or language are at higher risk of not being able to provide informed consent.

Part 6: Supporting people to make decisions

What is supported decision-making?

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

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

Applying cultural standards of care through a te ao Māori perspective of health assessment that many well applied and clinically proved Māori health models can provide and assist in this process of decision making. While not conventional that values are consistent and well adverse in Māori tikanga and kawa.

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

When full assessment for those entering the criminal system have not been given full options of assessment. Especially those experiencing mental disorders due to traumatic abuse and neglect.

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

International convention should be applied to gain statutory precedence of protection.

General Commentary

Advance directives made while people are well to outline choices during acute illness are a positive strategy for those with chronic diagnosed mental health conditions and are consistent with existing option of advanced care planning used in physical health conditions.

The choices expressed in advance directives would need to meet the same safety criteria used in the compulsory treatment order process.

Part 7: Seclusion, restraint, and other restrictive practices

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

Regulatory impact statements could be applied for optimal care and protection. Particularly with the use of types of restraints and techniques applied. Avoidance of any restraint's methodology should be considered, and alternative measures put in place. However, there needs to be a duty of care when actions of harmful behaviour may prevent the patient and staff to feel safe and protected. A wider response by other associated services should be considered.

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

Again, applying whānau centred te ao Māori models of health and approaches should be incorporated. Particularly as principles of te Tiriti are to be an overarching framework that includes associated values of tikanga Māori.

35. If any restrictive practices are allowed, what rules should be in the legislation about their use?
If tikanga Māori services are referred absolute protection of mātauranga Māori.

General Commentary
Restraint and / or seclusion should only be used when essential to maintain safety of the person or others.

Staff and patient safety should be prioritized as well as the use of least restrictive practices.

Part 8: Addressing specific population group needs

39. How would addressing culturally appropriate care in the legislation reflect te ao Māori?
Cultural values of this kind are embedded in the philosophies and best practice models that have been developed by Sir Mason Durie and Dr Rangimārie Te Turuki Arikirangi Rose Pere, Te Whare Tapa Whā, Te Pae Māhutonga, He Korowai, and Te Wheke model, along with many others have laid the foundation from which many health advocates can ensure quality and culturally standards of care consistent with mātauranga Māori are developed. We are reminded of the integral role these and other models have played in all our professional and personal lives and the impacts on whānau health and wellbeing.
40. How might addressing culturally appropriate care in the legislation affect particular population groups (for example, children, disabled people, etc)?

When information is not provided to all parties.

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

Whānau centred approach will need to apply on most case, especially if whānau are actively involved. Otherwise, if there is no immediate to whānau, there options for additional support should be offered. Particularly, for Māori perhaps iwi/hapū providers can support, given the Pae Ora (Healthy Futures) Bill introduces a Māori Health Authority and the consumer codes of practice act.

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

The concepts of Pae Ora that extends from the He Korowai framework, which moves whānau from whānau ora to Pae ora.

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

For Māori whakapapa rights are important to acknowledge and should be provided particularly for whānau have been displaced from them extend affiliated iwi/hapū due to many circumstances, including Whāngai and adoption.

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

When whānau refuse to participate in the whānau centred approach and at the time of treatment are causing more harmful behaviours. Therefore, creating barriers for wellness. Participation by all whānau members is required.

Children and young people

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

This should be an option; harmful behaviours of a child are learnt and should be abolished.

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

Through concepts of matauranga Māori where children immerse in their culture and whakapapa. Similarly, like the te Whāriki Model originally introduced by te kohanga reo Trust kaiako.

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

Duty of care and under the Convention of the Rights of a Child and Codes of Practice requires our taonga to be fully protected and those provide care to be held account and supported to provide the best interests of a child health outcomes in life.

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

When a child has disclosed to them experiences of harm, however proper measure of assessment needs to be carefully considered with child impact assessment to be applied at all ends of the spectrum. The cases of child removal are extreme and could have been avoided, so this requirement should be discussed with child rights health, social and education experts. Particularly, given the number of children in and out of state care, with Māori presenting as the highest to enter care.

50. What should support decision-making look like for children and young people?

It should be a child whānau centred approach, with the child at the centre and all whānau members considered as pillars of support, with a supporting cultural, social, educational and welfare system to support all whānau members to create a thriving, happy, child.

Disabled people

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

Should include the convention of the rights of person with disabilities.

People within the justice system (special patients)

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

Convention on the Rights of Persons with Disabilities

Part 9: Protecting and monitoring people's rights

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

Clinical and kaimahi hauora to ensure a whānau centred kaupapa Māori approach is applied for assessment of patients. With appropriate judiciary court decision reviewing all evidence supplied.

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

Extreme cases of harmful behaviour and a forensic assessment has been processed but the environment appears unsafe and clinical final decision should be made. With a full history of assessment provided. This avoids miscommunication.

Challenging clinical decisions

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

Full review of information of all measure taken by the judiciary system and in some cases via courts.

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

If there is any evidence of harm or potential risks or there has been miscommunication or people are misinformed leading to destress or external pressures and biases. Then a pause to final decision is required with appropriate investigation applied.

The role of police

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

Policy are mandated to sanction people for all causes of harm depending on levels of risk. In terms of patients in care, they should provide safety and protection for patients and workforce, including transport safety. Ideally, they should be working to ensure they are not forcing assists and creating unsettling environments, when unnecessary. They are not clinical trained or have culturally to provide that level of support. There, presence in situations with patients with extreme mental health disorders, requires further staff training for police and equally for health staff, seeking Police assistance.

(note: The role of police who have legislated authority to restrain people for acute safety concerns is essential support to manage episodes of aggression and behavioral disturbance with the least harm to all people involved).

Monitoring individuals' rights

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

There should be a mandated responsibility designated to the Children Commissioner including child experts in health and education.

A specific Mental health commissioner should appoint.

Kaupapa Māori experts to appointed to support the navigation of a wider cultural safe approach, which is whānau centred.

67. What should be the powers and responsibilities of these roles?
Statutory powers of autonomy to support whānau and powers of veto if decisions do not meet the standards of care for all parties.

68. What should be the complaints process for compulsory mental health treatment?
Complaints processes will need to apply a cultural safety standard and consider how complaints are communicated.

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69. Do you have anything else that you would like to share to help shape mental health legislation in Aotearoa New Zealand?

- The Act needs to guarantee full mandated autonomy to Māori as te Tiriti partner to the Crown to lead decision-making. This will ensure equitable approaches.
- As health professionals, we are cognisant of our obligations to ensure that Māori is appropriately represented and given equal opportunity to lead and influence all decision-making processes, which in accordance to te Tiriti, the Crown is obligated to protect procedures involving the social institutions of Māori like whānau and hapū authority over their tamariki and mokopuna. Addressing health needs in isolation of cultural, social, economic, health, education, environmental and judiciary injustices will only force ongoing review and escalate harm for all.
- This Bill and processes of review need to reflect the damage imposed by Mate Korona/Covid-19 pandemic and develop appropriate responses that are co-designed.
- The main concern is to retain options for the safe management of acute mental health crisis presentations that carry risk of severe harm to both the person and those around them. This is especially challenging in first time presentations in a hyperacute state.
- Ideally the care of those with mental health conditions would avoid compulsory treatment or restraint however there remains a need for this in a small number of situations. While the legislation is separate from operational factors, emergency departments continue to experience lack of adequate staff in facilities that are not fit for purpose, leading to increased difficulty providing timely care to all people presenting.