Repealing and replacing the Mental Health Act

®
Te Ao Māramatanga
New Zealand College of Mental Health Nurses Inc.
Partnership, Voice, Excellence in Mental Health Nursing

PO Box 77-080, Mt Albert, Auckland, 1350, New Zealand

Date 28 January 2022

To:
Ministry of Health
PO Box 5013
Wellington 6140
mhactreview@health.govt.nz

Tēnā Koe
Please find a brief outline about Te Ao Māramatanga - New Zealand College of Mental Health Nurses followed by our submission on the**:**

Repealing and Replacing the Mental health Act

About Us

Te Ao Māramatanga is the professional body and voice for Registered Nurses with specialist mental health, addiction and disability knowledge and skills in New Zealand. Our growing membership includes a number of nurses who have been awarded Fellowship or Whetū Kanapa status in recognition of their contribution to mental health nursing. Members include nurse practitioners, registered nurses, enrolled nurses, nurses who hold a mental health and addiction credential, retired nurses and student nurses. We have nurses with expertise in a range of settings- clinical practice, education, research, workforce development, policy, primary health services, secondary services, district health boards, non-government organisations and specialty areas including disability and addiction. Our members are spread in both urban and rural areas nationwide and link into local College branches. Te Ao Māramatanga now includes national branches for addiction nurses and disability nurses.

The College board brings a wealth of knowledge which we draw from to advance the care of people with mental health and addiction problems, and the wellbeing of people with disability, through the expertise and the professionalism of mental health nursing in New Zealand. Our governance structure is internationally recognised for its bi-cultural constitution and ways of working which includes a President and Kaiwhakahaere and a Māori caucus that supports our Board. We are very privileged to have Dame Margaret Bazley as our Patron for a number of years.

As an organisation we have set, promoted, and maintained the standards for the practice of mental health nursing in Aotearoa New Zealand - Standards of Practice for Mental Health Nurses (2012). These standards are used widely to inform nurses, employers and organisations concerned with the development and expectations of the mental health nursing workforce.

Te Ao Māramatanga strives to work in partnership; to be the voice of mental health nursing in Aotearoa and will always promote excellence in mental health, addiction, and disability nursing. We have the passion, commitment and expertise to do so. Providing nursing professional leadership on workforce matters is vital at this point and time to continue to develop and expand supportive services for people with disabilities, people with mental health needs and people with addiction needs. Moreover, nurses play a role in supporting whānau and communities with their health and wellbeing.

Te Ao Māramatanga is honoured to have Mātau Ron Baker as Kaumātua, and we are also very privileged to have Dame Margaret Bazley as our Patron for a number of years.

As a Professional body we submit the following feedback

Ngā mihi nui

RH TOIA.

Raeleen Toia (Kaiwhakahaere)
Te Ao Māramatanga – New Zealand College of Mental Health Nurses Inc

Hineroa Hakiaha (President)
Te Ao Māramatanga – New Zealand College of Mental Health Nurses Inc.

Submission of Te Ao Māramatanga; the New Zealand College of Mental Health Nurses Inc.

Background

The College welcomes the opportunity to make this submission on transforming our mental health legislation. The need for replacement of the current legislation was strongly signalled in the He Ara Oranga report of 2018, and over recent years some issues have become prominent that need to be considered in the reform process. This submission comes with a document outlining the nature and role of the College. In developing the submission we conducted several webinars with College members over late 2021 and early 2022. These were well attended and generated the points to be addressed in our submission. We also sought and received submissions by email which have been integrated into this submission. Because we received a diverse range of views we have presented both our final position on key issues, as well as comments that provided additional context to these issues. The College stresses that many of the changes needed for transformative change, are not part of the legislation, they are part of the operational context and necessary for the recommendations to be achieved. These include issues such as workforce development, funding models and configuration of services.

The College believes there are some aspects of transforming mental health law that remain unaddressed and/or need strengthening. Some of the significant gaps include and are not limited to, the recognition of the long history of colonisation in Aotearoa New Zealand and the positioning of the MH Act within this colonial mindset. Discussion around the associated inequities, intergenerational trauma and trauma arising from the use of the current Act could provide further context for the need for transformational change. There is no mention of the impact of antipsychotic medication on a person's health and the need to look broader at other therapeutic modalities including traditional therapies such as Rongoa and Mahi a Atua.

The College supports the aspirations expressed in the consultation document to developing legislation that is grounded in Te Tiriti o Waitangi and the obligations Te Tiriti creates for the Crown to ensure equality and equity for Maori. We note that this obligation is not being met currently, in the health sector or in Aotearoa society generally. Specifically in relation to mental health we note the historical and contemporary disproportionate use of mental health legislation with Maori, most dramatically illustrated by large differences in use of provisions such as community treatment orders, and in use of coercive practices such as seclusion. New legislation, therefore, begins from the position of New Zealand's history of colonisation, and ongoing practices of colonisation. We begin from a position of structural inequality which both contributes to the high level of mental health need for Maori, and the way mental health legislation is used in what is fundamentally a monocultural western system of health and health care. We share the aspiration of the consultation document that new legislation will address these historic and contemporary inequalities.

From a nursing perspective we approach this submission in terms of the ethics of nursing and nurses' duty of care. We see our ethical commitments being fulfilled when the practice context, including legislation, enables nurses to work in collaboration with the person and their whanau. We see it as important that service provision enables nurses to make minimal use of legislation in mental health care. This includes the provisions of legislation, and means that the legislation needs to include processes that have the capability of avoiding making decisions against the wishes or consent of individuals. As we note elsewhere in this submission legislation does not act alone, but needs and adequate workforce to enable supportive care to be provided, and use of legislation to be minimised.

The College also supports the aspiration of the consultation document to replace the current legislation which arises from and embodies a western medicalised view of distress (as disorder or illness) with legislation that fundamentally reorients mental health care towards supporting people experiencing mental distress without that support being conditional on people having to accept the medicalisation of distress. We envisage a mental health sector, of which mental health legislation is part, as a system that is responsive to people's needs rather than being driven by treatment imperatives. We recognise that legislation is only one aspect of the mental health system, but we urge that any new legislation play its part in transforming how mental health is understood and how services are provided.

The College notes that there is some tension between the aspirational statements of the background section and early parts of the consultation document, and the later questions which in our view appear to imply that new legislation will in large part be similar to existing legislation, with processes of compulsory assessment and treatment, professional assessment of mental state and capacity, and regulated powers of detention. The College is concerned at the possibility that the aspirations of the consultation document, and those expressed in He Ara Oranga may be subsumed in new legislation which is little different to the existing Act. The Ministry needs to ensure that the term 'transforming' is meaningful, not merely window dressing.

We urge the Ministry to clearly articulate what the rationale for having mental health legislation is, rather than assume that there needs to be separate specific legislation. In raising this issue we note that mental health care is increasingly being mainstreamed into primary care and community providers. Separate mental health legislation has always been part of the New Zealand legal system but the need for this needs to be articulated, and alternatives considered. The context of stigma needs to be considered. In many areas stigma is being addressed by integrating mental health awareness and responses across different social sectors and professional disciplines. This review of mental health legislation should consider whether the time is right to follow other recent changes and consider integrating provision for mental health care within generic legislation. In many areas, such as regulation of restraint and assessment of capacity, there are existing provisions in other statutory instruments such as the Health and Disability Code, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017, the Protection of Personal and Property Rights Act 1988 and others. Thought should be given to why it is thought necessary to have specific mental health legislation and whether the provisions legislation might contain could be adequately addressed in existing or new generic legislation.

In this submission we have made comments in response to the questions provided in the template, but we consider the questions do not encompass all the issues that need to be addressed. Some of these issues cannot be addressed in the wording of the legislation, however the wording of new legislation will create obligations that require development and extension of the mental health workforce. We note that mental health legislation internationally has traditionally reflected medical decision making. That is because mental distress has been seen as illness, rather than a personal experience. While there was historically some merit in this model of medical paternalism as an alternative to the purely custodial/juridical model that preceded it, we believe that the time of medical paternalism as a basis of responding to mental distress has passed and there is a need for a new social compact on responding to cultural, psychological and social distress. Legislation alone cannot change the currently dominant model of mental health care, but it can send a powerful signal about what model of mental health and wellbeing is appropriate in a modern diverse society.

In developing this submission we have not responded to every question in this template, in particular we have not made specific submissions on how the needs of the populations referred to in section 8-10 should be addressed. We believe that any submission on those matters to be premature at this stage. The “major submissions” listed below are matters that we believe apply to all populations.

Particular aspects of the consultation document that the College strongly supports are:

1. The commitment to having legislation that has embedded within it the principles of Te Tiriti o Waitangi, and which reflects a Maori world view.
2. The commitment to having legislation that moves away from a westernised medical view of mental health in favour of a person-centred view of mental health. We consider that the new legislation needs to be carefully constructed and worded to make it clear that this new legislation is not primarily focussed on assessment and treatment of illness, as the current legislation is, but on support for people in times of distress, and providing safe environments in which people can be supported without resorting to coercion as the only option.

3. The move towards supported decision making for any situations in which decisions may be made that are against a person's consent. This is the standard contained within the UNCRPD and we believe this standard needs to be an absolute commitment of the new legislation. We emphasise that this should replace medical decision making with supported decision making which is NOT at the discretion of a medical practitioner. The new legislation should be seen as an opportunity to move away from medical paternalism.
4. Reference to the use of advance directives. Advance directives are now common place in health care and are consistent with the idea of supported decision making. While there is a lot of detail to work through, as a result of this submission we want to see a commitment to developing legislation that recognises consumers' rights to complete an advance directive and to have that advance directive respected in any acute care situation.

With this submission we accept the invitation to re-imagine mental health legislation in Aotearoa / New Zealand.

Major submissions

In order to highlight the major areas of change that need to be addressed in this review of legislation our major submissions are given as bullet points below. The points are further developed within the submission.

1. As an initial step in the transformation process the Ministry should clearly articulate and seek consensus on the need for separate mental health legislation.
2. Any new legislation should include a binding commitment on services to embody and reflect Te Tiriti o Waitangi.
3. Any new legislation should be consistent with New Zealand's commitment to the United Nations Convention on the Rights of Persons with Disabilities.
4. Any new legislation should realise the aspiration of the consultation document to a model of mental health that is not based on a western medicalised view of human distress.
5. Safety and support should replace risk and compulsion as guiding principles of new legislation.
6. Every health care decision in which an individual cannot fully participate should be made using a supported decision-making model, not a substitute decision making model.
7. The basis for decision making in (6) should be assessment of capacity, not mental disorder, risk, or dangerousness.
8. An end to seclusion. New legislation should provide no legal power of seclusion.
9. An end to community treatment orders. Community treatment orders should not be part of new legislation.

10. The primary focus of any legal restraints on individuals' rights should be on the obligations of service providers, not on the restrictions imposed on individuals.
11. Any new legislation should be accompanied by a commitment to resource its provisions, in terms of workforce training, funding and funding models, and service provision.

Language and mental health legislation

Language is an important influence on the way we think about issues. In the context of mental health care our language has undergone many changes since our first mental health legislation was adopted in 1846. The history of mental health is rich in linguistic twists and turns, including terms such as "lunatic" (1846) and "defective", "idiot", "imbecile", "mentally infirm" and "feeble minded" (1911), "mentally subnormal" (1969), and "mentally disordered" (1969 and 1992). We need to think about what is appropriate language in the 21st century, and that language should reflect the increasing acceptance of a more social, rather than biomedical, understanding psychological distress and illness. Our current mental health legislation reflects a medicalised approach to mental health, and it is important that new legislation gives meaningful effect to the aspirations expressed in the public discussion document: to mark "a significant shift away from a Western, medicalised approach to mental health care and treatment and mental health legislation (p. 14)." Such a shift will require a change of language. The language of "mental disorder", "psychiatric assessment", "compulsory" and "assessment and treatment" position our mental health legislation firmly with a coercive psychiatric/medical paradigm. It will be necessary to change this language if the shift away from a medicalised approach is going to be achieved.

Below we have redrafted the name of the current Mental Health Act and the long title to show how new legislation can embrace terminology that reflects the current era. We are not suggesting this redraft as the wording for new legislation. We are just wanting to illustrate how new legislation could look different. We should not simply draft new provisions and procedures that attempt to achieve different objectives but trap us in the old coercive psychiatric/medical paradigm. Examples of key changes are outlined below. Changes from the 1992 legislation to new wording are highlighted.

Suggested (hypothetical) name for new legislation: "Mental health and wellbeing (supported care) Act".

Long title: current MHA

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

Suggested

An Act to define the circumstances in which and the conditions under which persons experiencing mental distress may be provided supported mental health care, to define and protect the rights of such persons, to ensure their physical, personal, and cultural safety, to give effect the principles of Te Tiriti o Waitangi, and generally to reform and consolidate the law relating to the care and support of persons experiencing mental distress.

Some specific examples of language change are:

1. From "mental health" to "mental health and wellbeing".

This change in wording reflects the focus in the mental health sector and wider society that mental health is part of more general wellbeing, see for example in the name of the Mental Health and Wellbeing Commission. The proposed name reflects that the focus of a Mental Health Act should be the promotion of mental wellbeing, not merely treatment for illness. Wellbeing can be supported in the way care is provided, in the relationships developed by service providers, in the coordination of services, by providing services that are culturally safe etc.

2. From "compulsory assessment and treatment" to "supported care".

This is a very significant change in language which removes the coercive connotation of "compulsory", which is a legal obligation on a person, replacing it with "support" which is an obligation on care providers. The term "support" is also intended to signal what is expected to be another change of focus in the new legislation, from substitute to supported decision making. The terms "Assessment and treatment" are taken from the medical lexicon, reinforcing that supported care can only be provided under the aegis of psychiatric medicine, whereas it is our contention that the new legislation should embrace a social model of care. A role for psychiatry in working within the proposed new social model of care is happily accommodated within the notion of care, a term that is widely used by all clinical disciplines and social agencies. Rather than traditional psychiatric approaches to assessment, College members support the use of health and wellbeing models such as Te Whare Tapa Whā (Durie, 1985) to have status within the legislation. Another endorsed evidence-based framework is the Power Threat Meaning Framework (Johnstone, L., & Boyle, M. (2018). [The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*, 0022167818793289].

3. From "mental disorder" to "mental distress"

The term "mental disorder" shapes the current legislation as a purely medical/psychiatric matter, with strong connotations of disease. Although "mental disorder" is used in the DSM, the DSM usage is different to that used in the current mental health Act, where "mental disorder" is defined in terms of the changes in cognitive and behavioural functioning outlined in section 2. Committal under the current legislation does not require a medical diagnosis. Mental disorder is then qualified in terms of its consequences (serious danger) which has to be demonstrated for the Act to be applied. The term “mental distress” is not too different from “mental disorder” in that it is not a diagnostic term, it simply refers to changes in one’s emotional and psychological functioning. However as noted above “disorder” strongly suggests illness or disease, despite the Act not requiring a medical diagnosis. The term “mental distress” now has wide currency and is well understood by clinicians and the general public.

4. From “assessment and treatment” to “care and support”

This change also anticipates a change in focus from “treatment” to care and support. Treatment is a medical concept and that is a narrow focus for a mental health act. The care provided within a care and support framework, it just would not be given the central focus as it is currently. Similarly, because “assessment” is linked to treatment in the current legislation this indicates a clinical/psychiatric model of assessment. There is a need to take a strengths-based approach rather than deficit view of the person We believe that new legislation requires something like a preamble that sets out its purpose and some fundamental propositions about distress and mental wellbeing. These could include for example:

- The fundamental position of Te Tiriti of Waitangi in health and health care.
- Mental health and wellness is based on recognition of individuals’ diverse cultural and personal identities.
- That much mental distress is a result of trauma, and health service responses need to be trauma informed.
- Mental health care needs to be respectful, supportive and person-centred.
- The focus of mental health legislation is people receiving mental health service
- A statement on the rights of health consumers
- A statement on responsibilities of health providers.

Mental health units as sanctuary

Much of the focus of current legislation is focussed on commitment under section 11 and the other initial stages of the Act. This creates a key role for inpatient services under any legislation. In most inpatient mental health units in New Zealand most patients are held under one or other of the compulsory provisions of the legislation. Voluntary inpatient care has become relatively uncommon. We are aware of practices in which inpatient services create a de facto standard of compulsory treatment for access to inpatient services. Similarly we are aware of practices in which clinicians, faced with restricted access to inpatient services, use the Mental Health Act to leverage access to an inpatient bed. The result of these practices, and the tendency for inpatient services to default to compulsory status as part of the admission process, is that inpatient services have substantially become compulsory care services. In such services medication is the main standby of treatment. Ironically many of these compulsorily admitted individuals are discharge from inpatient services with many of their important needs still unmet.

The College advocates that inpatient services are reimagined as places of sanctuary rather than primarily places of assessment and treatment. Inpatient admission can be a refuge for people with significant stressors in the community. Admission can also provide food and shelter; human connection; a sense of belonging; and feeling cared for. Inpatient mental health units may be considered "sanctuaries" as they are environments for emotional and physical safety that allow service users the opportunity to recuperate and rebuild through the supportive care of others. Within a sanctuary, people learn together how to resolve conflicts; have a voice and can contribute to and participate; in work that expresses themselves. They can learn together to adapt whilst still maintaining their sense of selves; and work toward their future goals. The sanctuary model is a template for changing the delivery of social services so that staff are better able to respond to the complex needs of trauma survivors and to the distress of individuals.

This change in the understanding of inpatient services would require that legislation used different criteria, and had different goals to current legislation. There would also be a need for a greater range of practitioners within such unit, in particular cultural workers and peer support workers. This is one of the examples in which a change in the mental health sector, while not being fully prescribed by legislation, would need to support the goals of new legislation and reflect its language.

Workforce

The mental health and wellbeing legislation we envisage cannot be provided with the current mental health workforce. There is a need for new workforces to support changes in practice. One example is in supported decision making. It is the position of the College, and is supported by Ministry policy, that supported decision making should replace the current model of substitute decision making. Supported decision making requires a workforce that does not exist currently. It is the position of the College that a peer workforce is developed that is specifically trained (by peer experts) in supported decision making. Currently many DHBs require DAOs to arrange for the presence of a Justice of the Peace if there is no family member present at the point of initial assessment. This is an ad hoc development that is not part of the current legislation. It recognises the need for the presence of someone who is not part of the mental health clinical system. However the JP currently has no formal decision making role. The role is purely observational. While such a role is not entirely without merit in terms of transparency, it adds little to the assessment process. The JP cannot influence the decision-making process. We envisage the role of Decision Support Advocate (DSA) as a role for a peer worker which would be a formal role within new legislation. The DSA would have the role of working directly with consumers to support their decision making. This is one example of a new role that requires resourcing, specification of the role, a process of accountability.

Another area of workforce training needed is in working with advance directives. Some clinicians see these an either/or decision – to follow the preferences expressed in an advance directive or not – not as a basis for negotiation of care based on individuals' preferences. We envisage an expansion of the peer workforce with the role in mind of supporting individuals in writing their advance directives. Many mental health services are currently provided by Maori providers, either within kaupapa models or as part of mainstream services.

Part 3: Embedding Te Tiriti o Waitangi and addressing Māori cultural needs

If there was mental health legislation how can we:

- make the new laws fit with Te Tiriti o Waitangi?
- have Māori ideas in the new laws?
- make sure the new laws respect the rights of Māori?

As we noted above in our Major Submissions, the College believes that transformation of mental health legislation, and mental health care in Aotearoa, begins with recognition of Te Tiriti o Waitangi and the historical and ongoing impacts of colonisation. Māori are still treated as if they have a lower mentality, in prisons and in psychiatry there continues to be post-colonial attitudes which has now been normalised into our whānau. Transformation also needs to acknowledge the strengths and resources of Maori communities and of Maori models of health and mental health, for example the Te Whare Tapa Wha model of Ta Mason Durie and the practice examples of Dr Hinemoa Elder at Tairawhiti with the youth population. Any new legislation needs to be developed to meet the needs of whānau, so iwi justice is enhanced and restored.

Implementation of new legislation needs to follow a partnership with iwi using co-design approach for the structural changes that will be required – all around the table, noting that there will be multiple iwi to engage with. It should not be assumed that all iwi works the same way. Transformation requires that services work with each iwi in each region. Engagement requires awareness of the kupu and language of partnering and what it means in that space.

Realising the vision of legislation informed by Te Ao Maori has workforce implications. There needs to be development and support for all mental health practitioners to apply an equity lens, to challenge the institutional racism and develop a shared language. Processes must not be DHB centric, hence the need for structural change and engagement with the communities. Submission supports the recommendations within He Ara Oranga and the Māori Health Action plan. Workforce development needs to emphasise engagement with whānau and iwi as a priority and then assessment and support built on engagement.

New legislation that aspires to embedding Te Ao Maori requires that funding follows the structure and models that support the new Act. Some of these issues are outlined in David Clark's paper on Access and Choice. Te Ao Māori approaches could include further support for restorative justice-based youth courts using a dignity of risk approach. Marae based process can also support embedding Te Tiriti, through working with the whānau – the presence of a brown face can help make services accessible to Maori. Transformation should support a by Māori - for Māori approach. There needs to be more options for treatment including traditional healing such as rongoa, tohunga, Mahi a Atua.

Part 4: Defining the purpose of mental health legislation

- What could it look like if there was no compulsory treatment in Aotearoa New Zealand?
    - How would we support people through times of extreme distress?

- If there was mental health legislation, what should its purpose be?

- If there was some compulsion, what would it look?
    - When would it be needed?
    - What purpose would it have?
    - Who would be involved?
    - Where would it happen?

There were no submissions specifically on the question of whether there should be "compulsory treatment" or not. Most members seem to accept that there is a need to provide support for people with high levels of distress and at times of extreme distress. We note that the language of this question ("compulsory treatment") is from the 1992 legislation and in our opinion, this is not appropriate language to refer to mental health care in the 21st century. However we have noted that the articulation of a rationale for having separate mental health legislation is an early priority for the transformation agenda.

We note that it is possible to provide high levels of support without that support being "treatment". "Treatment" reintroduces the western medical model which the consultation document says should not be a feature of new legislation. Consistent with our submission about language, we think that new legislation should use a term such as "mental health and wellbeing legislation" to emphasise the intent to promote wellbeing, not just provide treatment.

We think new legislation should not use the term "compulsory treatment" as that language implies that distress is an illness that needs treatment, rather than a human experience that needs compassionate support. If people are to have decisions made without their consent they should have meaningful and effective support to make those decisions. These do not need to be thought of 'medical decisions' but could be thought of 'support decisions'.

We refer to the literature on supported decision making when considering legislation that anticipates health or social agents making decisions on behalf of individuals. In the case of community treatment orders we heard opinion that there should be no such orders in new legislation, although some members did support some form of community treatment order.

The following passage captures the view in favour of discontinuing community treatment orders:

CTOs were introduced in 1992 as part of the move to community-based care, which had been under way in the preceding decade. Since their introduction use of CTOs in Aotearoa has increased significantly, with marked regional variation. Aotearoa has one of the world's highest rates of use of CTOs. CTOs, as noted in the consultation document, impose significant conditions on individuals' civil liberties. In addition the status of being 'under an order' can contribute to stigma and marginalisation. There is a grossly disproportionate use of CTOs with Maori and Pacific people. CTOs are also more commonly used in areas with high levels of social deprivation. This suggests that CTOs are used to medicalise distress among populations with high levels of social need. There is little evidence to suggest that rates of CTO use are related to rates of mental illness in the community. The evidence on effectiveness of CTOs is poor. The only randomised controlled trials, most recently the English OCTET study, have found no benefits in outcomes to consumers. The argument is frequently made that CTOs have the benefit of prioritising consumers for access to services. But it does not seem rational or justifiable to make prioritisation for services conditional on imposing limitations on individuals' rights and freedoms. An alternative would be to provide a legal mechanism which obliged services to provide increased support for consumers with high needs, shifting the emphasis from limitations on consumers' rights to obligations on the part of services. We recommend, therefore, that provisions for CTOs are not included in new legislation, and are replaced, if they need to be replaced at all, with some form of instrument that shifts the focus of obligation from consumers compliance with medical directions, to services' adherence to providing increased support”

Views more in favour of community treatment orders were:
“There needs to be counterbalance for those tangata whaiora who have high and complex needs, long term enduring who have limited capacity to sustain a level of recovery – who require high level of residential support – without the CTO, one of the unintended consequences could be that their mental health deteriorates and the efficacy of medication takes longer or is not one an effective choice. Whānau distress is another factor that needs to be considered”

“I disagree with some of this. While I have heard of some of this research around outcomes of community CTOs you also need to remember that some people are on CTOs because they are or have a history of being seriously mentally unwell and if not unwell could end up in prison. CTOs are a way to monitor people who have potential to be violent. Now I know not everyone who has a mental illness is violent. You talk about patient rights, but the community and staff have rights to feel safe also".

We encourage the Ministry to consider how the issues thought to be addressed by a CTO could be addressed using alternative measures that do not subject individuals to compulsory community treatment. The idea seems anachronistic, and the abolition of CTOs would signal that Aotearoa is serious about meeting its obligations under the UNCRPD. We note that under current legislation the option of re-initiating the MHA exists if it is considered necessary. We don't want to suggest that CTOs should be omitted from the legislation in favour of an easy process of re-initiation of compulsory care. We do think it is undignified to subject individuals to this form of legal order while they live in their own homes. The CTO, it needs to be remembered, is a reformulation of the 1969 provision for "extended leave" so despite its wording it is based within a model of institutional care, which we believe is inimical to the aim of the consultation document to transformation.

Part 5: Capacity and decision making

- What needs to be considered when deciding about when to use legislation to make someone do something they don’t want to?

The default position should be that no-one should be forced to do something they don’t want to do. This question is asking about forced detention or forced medication. These are actions that should only be contemplated in extreme situations, and then only for the purposes of containing a highly unsafe situation. The focus should still be on supporting the person, understanding their distress and limiting any coercive intervention to the absolute minimum necessary, and for the least amount of time necessary.

It is now clear that the only grounds for forcing someone to do something without their consent is if the person lacks *decision making capacity*. For this reason clinicians need to be trained in assessment of capacity. The legislation should make it clear that mental illness, even severe mental illness does not equate to lack of capacity. If someone is assessed as lacking capacity they should have access to support in their decision making, and the capacity assessment should be able to be reviewed.

We note that the formal assessment of capacity is a new role for most mental health clinicians, including nurses. Capacity within new legislation needs to be defined in a way that lends itself to assessment. For example the Appelbaum & Grisso model of capacity assessment is almost universally accepted and could form the basis for a model of capacity of our new legislation, including a contemporary recovery focused approach by Slade [https://onlinelibrary.wiley.com/doi/abs/10.1002/wps.20412]

It is crucial, however, that there is training in capacity assessment for all clinicians. This role should not be seen as the exclusive province of doctors, or indeed of health professionals. The legislation should recognise the diverse range of practitioners who can undertake capacity assessment, perhaps with some form of micro-credentialing. Like assessment of capacity, any process of accreditation of practitioners to assess capacity should not be dominated by medical practitioners. This should be seen as a generic role.

If someone not having decision making capacity was one of the reasons, what else, if anything, needs to be considered in relation to mental health.

The literature on capacity assessment makes it clear that the concept of capacity is not black and white, and needs to be considered in relation to the issue that led to the question of capacity being raised. We note that capacity is influenced by anxiety and other contextual factors, showing the need for support in the process of capacity assessment. This should include cultural support where that is requested. The College is reluctant at this early stage to suggest specific additional criteria to be considered but would welcome involvement about future development of criteria.

Part 6: Supporting people to make decisions

- How should people who do not have capacity be supported to make their own choices?
    - Who should be involved?
    - Where should decisions be made?
    - What type of supported decision-making tools could be used?
    - When should supported decision making be used?

We have provided some comments about support in the first section of this submission. It is the submission of the College that supported decision making should be the default model in any new legislation, and that the sources of support need to be determined by the individual. These could include extended family or whanau. We recommend that the peer workforce have a role in supported decision making, and that this role is not assigned to clinicians. In addition, it will be important to include representation from the person's culture. There would be an emphasis on peer/RN delivered services in the community embracing the NGO workforce who bring a compatible paradigm to system change and risk. There would be whānau involvement and the upholding of advanced directives.

Decisions are best made in an environment whereby the service user feels at their safest and most secure, this can be at home, in a community group setting or on the marae. There are a range of tools that are recommended in the literature and within other discipline training such as social work. What is vital is the interpersonal skills required of the clinician involved to have this important conversation with service user, and underpinned by the notion of procedural justice, human connectedness, and the cultural competence and cultural humility of tau iwi staff. [Hamer & Lampshire. (2017). Legal and ethical aspects in mental health care. In Mental health: A person centred approach, (2nd ed) Cambridge University Press.]

The notion of supported decision making needs to be an approach to care that should start at the beginning of a service users' journey with the services, not only at the point of semi urgent or crisis presentations; this can also be considered then as an earlier intervention approach in tandem with the advanced directives. The skills of the clinician can be developed to offer this paradigmatic approach to crisis assessment within the acute community and inpatient teams.

A clinical model would, in our view, defeat the purpose of supported decision making and result in reversion to a substituted decision-making process under another name. The Ministry needs to commission a separate review of what is an appropriate decision-making tool. The College emphasises that the tool is not the only component of this aspect of the legislation. The *process* of decision making is equally important. This is where different cultural models should be considered and available to consumers.

The College restates the point made earlier that other current legislation contains provision for capacity assessment. That legislation may be adequate to apply in the mental health context. Consideration should be given as much as possible to not having mental health legislation in a separate silo, but as much as possible integrating all legislation on capacity. The "fusion" model of capacity legislation suggests such a model: Szmukler, G., & Dawson, J. (2011). Reducing discrimination in mental health law—the "fusion" of incapacity and mental health legislation. *Coercive Treatment in Psychiatry*, 97-119.

People and their whanau accessing mental health services should be encouraged to develop statements of advance preferences and develop a safety plan, with safety being defined by the person with mental distress. The workforce will need to be prepared to support people to complete and implement their advance directives confidently. The workforce would plan collaboratively how to facilitate supported decision making which needs to be a statutory process outside of the clinical agency – not one-sided process by the clinician.

We understand that the New Zealand Law Society is preparing an advance directives (AD) paper with Australian and New Zealand psychiatrist for new legislation. These things need to be part of the new legislation, e.g. some people have nominated a clinician to help them write their AD, however the College believes this is best to be done with non-clinical support workers, a workforce that needs development for this role. There needs to be more advocacy from the MH Tribunal process, or whatever new process is envisaged, for alternatives to compulsory treatment

Part 7: Seclusion, restraint and other restrictive practices

When thinking about the use of restrictive practices, and with there being a commitment to seclusion being eliminated:

- What ideas do you have for how we use legislation to keep all people safe in an inpatient unit, both whaiora and staff?
- If these ideas allow for some restrictive practices how might legislation protect people?

Firstly, a comment about coercion and compulsion. Coercion has been evident in the system for many years as demands for acute care increase and therefore the larger number of service users who present in extreme states often due to being under the influence of substances such as methamphetamine. This often puts nurses in the conflict of wishing to provide supportive care however feeling compelled to undertake coercive practices to reduce risk to self and others, particularly in acute units. As the built environment and current staffing levels are less than adequate to create a safe sanctuary, and considerable moral distress for nurses, therefore future practice needs to be supported to reduce the only option of coercion.

It is the absolute position of the College that seclusion should not be allowed for in the new legislation. The College does not support the use of seclusion and this practice needs to be stopped and removed from legislation. The case for seclusion free services is now undeniable and in any case is a policy commitment of the Ministry of Health. Every DHB, in collaboration with Iwi, needs to commit to how this is done. Mental health nurses are at the forefront of supporting people with mental distress and, because of this, have become the custodians carrying out restrictive practices, such as restraint and seclusion. These practices are at odds with our professional values and professional identity. There is no evidence to suggest seclusion is therapeutic and this creates moral distress for some nurses. However, seclusion is seen by some nurses as a necessary evil within our risk averse environments. This has led to concerns by some nurses on the front line that they do not know how to safely support people who are extremely distressed and that assaults on staff and others may increase without the use of seclusion. Nurses are the health professionals most involved in the operationalisation of seclusion and we wish to make it clear that we do not see a place for seclusion in the new legislation. Such a provision would be extremely retrograde in our opinion, and would defeat the other objectives of reform.

In keeping with the move towards common standards across the health sector we think that any provision for restrictive practices should be addressed within the Health and Disability sector standards, not within mental health legislation. To include provisions in mental health legislation suggests that mental health care is fundamentally different to general health care, a proposition that we reject.

In developing new legislation the Ministry needs to address the design and construction of facilities, staffing and workforce training, and models of service delivery that support seclusion-free services. In our opinion it is not acceptable to perpetuate the use of a practice which is harmful, traumatic and which undermines relationships between health practitioners and consumers.

Some submissions to the College raised an issue about safe management of acutely agitated or aggressive individuals in the absence of seclusion. This is an issue that has been well rehearsed in the seclusion reduction legislation. Methamphetamine is often mentioned in this context. We understand that the MOH/HQSC are currently developing guidelines for safe practice with the aim of reducing coercion/compulsion, and also some management guidelines for intoxicated/drug related presentations and that should be used to inform service development. We look forward to environments and guidelines that support nurses to deliver more supportive practices and ability to use their expert skills that they currently have in their kete to create collaborative and non-coercive approaches. We do not believe that transformation of mental health legislation should be constrained by clinical problems that are amenable to solutions that do not involve seclusion.

The College recommends that in preparation for legislation that does not authorise seclusion the Ministry redoubles its current work in seclusion reduction and reduction of restrictive practices, to consider how services and practices need to be supported in a zero-seclusion context. This includes staffing mix and levels, physical infrastructure, and staff training.

We support a number of evidence-based alternatives to seclusion. For example:

- Open Dialogue approaches. Nurses will need to be properly resourced to lead this approach of spiritual and psychological holding.
- We see that violence and aggression inherent in society and our current risk averse system pushes nurses into using restrictive practices. The Power Threat Meaning framework (PTMF) can help nurses to understand that the person’s fear response which can lead to aggression is based on traumatic events in life of whaiora.
- Emphasis on developing therapeutic relationships based on respect and trust. The provision of person-centred care with the values of manaakitanga and whanaungatanga at the forefront of nursing practice. Understanding self as a cultural bearer, effective communication, the art and skill of de-escalation, sensory modulation, safe staffing, working alongside peer support workers, trauma informed care, access to nature and pleasant, bi-cultural environments and cultural practices can all reduce the need for seclusion.

We are mindful how mental health services are judged by the media and members of society when things go wrong as well as the stigma of people with mental distress as being dangerous. There will need to be systemic changes to support the transformation.

Part 8: Addressing specific population group needs

Cultural needs

There are certain populations which will need special consideration under any new mental health legislation, and we want to find out how legislation should address the needs of these groups. These include people with different cultural backgrounds; disabled people; families, whānau, āiga, and carers; children and young people; and people within the justice system.

Addressing cultural needs

- How do we make sure that everyone's cultural needs are supported?
- How to ensure people's rights are protected and monitored

The system needs to support care led by Māori for Māori, there are examples already of this best practice approach e.g. Hinemoa Elder at Tairawhiti with the youth population Major gaps – use of Rongoa and traditional healing, and Mahi a Atua [https://communityresearch.org.nz/webinar/mahi-a-atua-treatment-for-racism]. There needs to be specific funding to develop these models for new experts- not solely MH clinicians – e.g. whānau ora, navigators and the importance of developing RFPs to recruit and progress this workforce

We are yet to see the changes with the Māori health authority – as Ta Mason Durie envisions "we are all on the same track for the betterment of Māori". Services will need to enhance and access better models to engage whānau, and Te Whare Tapa Wha and the focus on wellbeing needs to be enshrined within the new law. We need to be aware of the contextual issues, and the paradigm shift of new Act e.g. reimagine the policies that will be developed to includes recommendations from He Ara Oranga, equity etc. and the underpinning precepts of the social model of disability approach – social model of madness - and the non-pathologising of distress, particularly the issues of long-Covid. These paradigms are compatible with the new legislation of capacity and competency

Provision needs to be made to have mandatory reporting on the Act's KPI's -similar but broader than the current Directors report – this obligation must be embedded in the Act. Workforce development – who and how - cultural model supports all initiatives - using a capacity approach - working within a supported decision-making process. If the new legislation achieves its aim of embedding principles of Te Tiriti o Waitangi and addressing Māori cultural needs that will provide a good basis for addressing the cultural needs of all populations.

Part 8: Addressing specific population group needs

Respecting family and whānau

There are certain populations which will need special consideration under any new mental health legislation, and we want to find out how legislation should address the needs of these groups. These include people with different cultural backgrounds; disabled people; families, whānau, āiga, and carers; children and young people; and people within the justice system.

Respecting families and whānau

- Do you think the law should say that the family / whanau of a person can be part of their care?

Current legislation already does this, and was amended to strengthen these provisions. The College takes it as self-evident that families / whanau should be included in care. This is standard across the health sector and mental health, including any "compulsory" mental health is not an exception.

The Act needs to be developed to meet the needs of whānau, so iwi justice is enhanced and restored Therefore we support a whānau presence in process of the Act, and the upholding of this stated in the advanced directives. Need for a non-westernised view, so bring in the TOW at all levels of the law and systems change to provide better models to engage whānau, increase the skill set of staff to engage, and legislate for Te Whare Tapa Wha as basis of practice. Also look to build staff relationship across MH, Addiction and Disability as the nurses in this specialists' groups really shine with their skill set to engage whānau and whaiora. As noted above, this is likely due to the social model of disability approach and the non-pathologising of addiction. These paradigms are compatible with the new legislation of capacity and competency

Safety first – not risk averse – a safe whānau focus needs to be front and centre of clinicians practice supported by their obligation to demonstrate cultural competence and cultural humility. As it is essential to include the impact that current care and treatment has on physical health – tinana of whaiora – we also need to extend support and recognition of the impact on whānau health and wellbeing.

What should happen if someone does not want their family / whānau to be part of their care?

The College takes it as self-evident that individuals have a right to decline to involve their family / whanau. However a one-off refusal should not exclude family / whanau over the period of care.

Part 8: Addressing specific population group needs

Children and young people

There are certain populations which will need special consideration under any new mental health legislation, and we want to find out how legislation should address the needs of these groups. These include people with different cultural backgrounds; disabled people; families, whānau, āiga, and carers; children and young people; and people within the justice system.

Children and young people

- How do you think compulsory treatment should work for children / and young people?
- How would the family / whānau be a part of this care?

The underpinning principles highlighted in our submission apply across the life course with obvious legislation already enshrined in the care of children and young persons that needs to interact with mental health law.

Part 8: Addressing specific population group needs

Disabled people

There are certain populations which will need special consideration under any new mental health legislation, and we want to find out how legislation should address the needs of these groups. These include people with different cultural backgrounds; disabled people; families, whānau, āiga, and carers; children and young people; and people within the justice system.

Disabled people

- How do we need to change the laws to make sure the rights of disabled people are protected?

We are aware that the rights of disabled people are protected through the following Act – with its philosophical underpinning of the social model of disability which proposes that a person’s disablement is caused by the ways in which society is organised, rather than by a person’s impairment or difference; the social model looks at ways of removing barriers that restrict life choices for disabled people, and increasing their access to the same rights and responsibilities enjoyed by all citizens. People with intellectual disability or dual disability – having a psychiatric diagnosis and intellectual disability will at times require compulsory treatment due to a perceived risk to self or others, however, were disadvantaged in having their specific needs met through mental health legislation. The *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (New Zealand) (ID (CC&R) Act) values the social model of disability and the philosophy of autonomy, choice and normalisation, and contains specific statutory roles designed to protect the rights of people subject to the ID (CC&R) Act. These roles are care coordinators, care managers (both roles held by registered health practitioners), specialist assessors (usually a psychologist) and medical consultants. The role of the district inspector also applies to this legislation. The role of the care manager is central in the processing of applications, liaising with the courts and ensuring that assessments, plans and reports are implemented and that regular clinical reviews take place. We believe that the new Act would benefit from similar precepts within this legislation, and adoption of some of the principles within a social model approach to mental distress [Reframing the nurse's role through a social model approach: A rights-based approach to workers' development. Beresford, P. (2004). Journal of Psychiatric and Mental Health Nursing 2004 Vol. 11 Issue 3 Pages 365-368]

Part 8: Addressing specific population group needs

People in the justice system

There are certain populations which will need special consideration under any new mental health legislation, and we want to find out how legislation should address the needs of these groups. These include people with different cultural backgrounds; disabled people; families, whānau, āiga, and carers; children and young people; and people within the justice system.

People within the justice system (special patients)

- How can we make new laws about compulsory treatment orders safe for people who are involved in the justice system?

We did not receive specific comment on this issue

Part 9: Protecting and monitoring people's rights

How to ensure people's rights are protected and monitored.

- What you think needs to change for the courts to be accessible for those with mental health issues?
- What do you think should happen when someone does not agree with a clinical decision?

The current processes of second opinion in relation to compulsory treatment are sometimes seen as a rubber stamp, as the clinician from whom the second opinion is requested is usually a colleague of the original clinician. While this may a perception in some cases, it is still important, as the experienced sense of fairness is largely based on perception, and in any case, it seems reasonable to expect a more objective process for providing a second opinion. It is the College's view that there should be some form of non-clinical oversight of decision making. Given our earlier submission that all decisions in which individual's capacity might be in question should follow a model of supported decision making, the College recommends that any model of review of decisions should be consistent with the supported decision-making model that we have recommended for the legislation.

In terms of access to the courts, the peer support model recommended in relation to supported decision making should also apply to individuals when accessing the court. This would be in addition to access to legal representation as peer support workers should not be expected to fulfil that role.

One point that we wish to make about monitoring rights is that the current legislation, with its focus on procedural fairness at an individual level, neglects the need to monitor rights at a population level. Previous mental health legislation (before 1992) included a statutory obligation to report key statistics, such as the number of people in hospital, number of discharges and transfers etc. While many of these matters are covered in the annual Director's report, it is our submission that the new legislation should make specific provision for monitoring and publicly reporting on key outcomes. For example it was many years before the full extent of inequity in the application of mental health legislation was reported in the annual Director's report. The new legislation should commit to transparent annual public reporting of all key statistics. The exact nature of what is a 'key statistic' could be contained in a schedule to the legislation and reviewed as necessary. But the outcome we would like to see is that there is a legislated commitment to annual transparent reporting, and some detail about what will be reported.

Part 9: Protecting and monitoring people’s rights

Police

- What role do you think police should have in any new mental health laws?

We did not receive specific comment on this issue. We understand that police see their role in relation to mental health as part of their role of community policing. This means keeping people safe and where possible supporting people to access the services they need.

Police are the only practitioners with the power to restrain or detain individuals in the community, and that role requires an awareness of mental health issues and how they might contribute to calls for police response. This means there is a need for police to work closely with health and other agencies to ensure their responses are adequately health informed. Legislation needs to support collaboration between mental health services with police.

We support the commonly expressed view that police are not mental health clinicians and should not be expected to substitute for an appropriate mental health response to individuals in distress.

Part 9: Protecting and monitoring people's rights

- Ensuring people's rights are protected and monitored:
  - What could this look like?
  - Who could be involved?
  - What would you change or do differently?

As previously mentioned, we believe that some of the protection enshrined in the *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (New Zealand) (ID (CC&R) Act) that values the social model of disability and the philosophy of autonomy, choice and normalisation, can consider similar and specific statutory roles designed to protect the rights of people subject to the ID (CC&R) Act for the new Act.

Any additional comments?

Please feel free to add more pages if required