

Te Huringa Tuarua 2023:

Lived experiences of compulsory
community treatment orders

Ngā mātau ā-wheako o te
whakahau maimoatanga hapori e
whakaturehia ana

Te Huringa Tuarua 2023: Lived experiences of compulsory community treatment orders

A report issued by Te Huringa Mahara – the New Zealand Mental Health and Wellbeing Commission (Te Huringa Mahara).

Authored by Te Huringa Mahara.

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Te Huringa Mahara – the New Zealand Mental Health and Wellbeing Commission – was set up in February 2021 and works under the Mental Health and Wellbeing Commission Act 2020. Our purpose is to contribute to better and equitable mental health and wellbeing outcomes for people in Aotearoa New Zealand.

For more information, please visit our website: www.mentalhealthwc.govt.nz

The mission statement in our Strategy is “Whakawāteatia e tātou he ara oranga / clearing pathways to wellbeing for all.” Te Huringa Mahara acknowledges the inequities present in how different communities in Aotearoa New Zealand experience wellbeing and that we must create the space to welcome change and transformation of the systems that support mental health and wellbeing. Transforming the ways people experience wellbeing can only be realised when the voices of those poorly served communities, including Māori and people with lived experience of distress and addiction, substance, or gambling harm, are prioritised.

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Kupu whakataki | Foreword

In 2019, the Government accepted the recommendation from **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction** (Government Inquiry into Mental Health and Addiction, 2018) to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act)—an outdated law that is not aligned with our international human rights obligations.

Since then, the process to repeal and replace the Mental Health Act has been under way. While this work is important, we cannot wait years for changes to happen. We need to keep up efforts to shift from coercive treatment to choice-based treatment now, and ensure people are supported to make decisions about their health care.

Almost 7,000 people were under compulsory community treatment orders (CCTOs) in 2021. These people are members of whānau and communities, and are living and working in communities. Under the current legislation, they are also denied the right to make decisions about their health care.

More Māori are subject to CCTOs than any other population group in Aotearoa, and this is unacceptable.

It is crucial to base the new legislation on Te Tiriti o Waitangi, human rights, and supported decision making so that Māori, tāngata whaiora, and whānau have the right to make decisions about their care and support. It is also important to provide more meaningful options for people experiencing mental distress.

While legislation is being developed, we strongly urge that services and courts change their practices now.

We acknowledge that the factors influencing current use of the Mental Health Act and CCTOs are complex. For changes to happen in ways that genuinely support tāngata whaiora and whānau, we call on the Government to invest in a range of appropriate services that provide more choice about what works for people and whānau. We particularly urge the Government to invest in more kaupapa Māori services to provide culturally appropriate support for tāngata whaiora Māori.



Hayden Wano
Board Chair, Te Hiringa Mahara

Ngā mihi | Acknowledgements

Te Hiringa Mahara has developed this report with input from people who have shared their expertise and advice. We thank them for their guidance and acknowledge them here.

We are indebted to the people with lived experience of distress as well as whānau and family who shared their views with us. We honour your feedback and will use your stories to advocate for a better mental health and addiction system.

We thank Te Tāhū o te Ture—Ministry of Justice for providing the 2021/22 data on applications and CCTO outcomes for this report. We wish to thank Te Whatu Ora and Manatū Hauora for feedback on the draft report.

Finally, we extend our thanks to the reviewers:

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Whakamōhiotanga whānui | Overall summary

In this report, we focus on compulsory community treatment orders (CCTOs) made under section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act). CCTOs permit clinicians to compel people (tāngata whaiora) who are living in the community to be treated, typically with medication, without their consent. For the year 2020/21, 6,817 people were under CCTOs. This equates to 90 people under CCTOs per 100,000 in the population. Over the last five years, the courts consistently granted 88–89 per cent of the applications clinicians made for CCTOs. This means that almost 90 per cent of clinicians' applications progress to CCTOs.

The purpose of this report is to shine a light on the use of CCTOs in practice, by amplifying the voices of those with experience of compulsory treatment in the community. We are interested in understanding the impact of current practices specifically related to CCTO applications made and orders granted. Our focus is on the clinical review (application) and the court hearing (outcome) under the Mental Health Act.

In line with our legislative function, we intentionally focus on tāngata whaiora perceptions of CCTO processes and practices. We identify the clinical review and the court hearing as formal substitute decision-making processes under the Mental Health Act. These processes translate to CCTO applications and outcomes that Manatū Hauora—Ministry of Health (Manatū Hauora) reports publicly. These events take place daily in Aotearoa New Zealand across a range of service contexts. The perceptions and experiences of mental health and legal professionals with formal roles under the current Mental Health Act are also important for understanding what influences the use of CCTOs in practice; however, these voices are not the focus of this report.

We heard from people with lived experience, including Māori, tāngata whaiora, whānau, and family, about the use of CCTOs and the involvement of these people in clinical reviews and court hearings. First, we highlight some of the ways tāngata whaiora, whānau, and family spoke of being physically excluded from review and hearing processes. A second theme calls out ways that these decision-making events silence or override their perspectives. The examples of exclusion and marginalisation illustrate just how much some practices need to change before tāngata whaiora can be leading decisions on their own care and treatment, with support if needed. A third theme focuses on what we heard can be done now to improve practices under the current Mental Health Act, to protect mana and uphold rights to the greatest extent

possible, in advance of the new law embedding Te Tiriti o Waitangi and international human rights. A fourth theme highlights broader negative experiences of CCTO use.

Consistent with best practice under the Mental Health Act, clinical reviews and court hearings are opportunities for tāngata whaiora to make decisions for themselves with support if needed; rather than have decisions made for them. We want practice to be as consistent as possible with our international human rights obligations. The change that needs to happen is for services and courts to implement cultural and other practices that ensure tāngata whaiora as well as whānau and family perspectives are heard and tāngata whaiora lead in their decision making.

What needs to change?

Replacing the law

- We want to see the new mental health law based on supported decision making, and embedding Te Tiriti o Waitangi and a Te Ao Māori worldview.

Practices that need to change now under the current Mental Health Act

- We want to see a reduction in the number of applications made and outcomes granted for CCTOs, and in the rate of CCTO use.
- We want to see a reduction in the inequitable use of CCTOs for Māori and Pacific peoples.
- We want to see services and courts implementing cultural and other practices that ensure their processes hear the perspectives of tāngata whaiora as well as of whānau and family, and tāngata whaiora lead in their decision making.

While our priority in this report is to amplify voices of lived experience, we are committed to working with all stakeholders to help forge a different pathway that honours Te Tiriti o Waitangi and respects the rights of tāngata whaiora Māori and other people with lived experience. That pathway will be built on approaches that are effective in improving experience of services and improving outcomes for all people in Aotearoa.

Kupu arataki | Introduction

This report is part of a suite of monitoring reports (Te Huringa Tuarua 2023) that fulfils our legislative function to monitor and report on mental health and addiction services and advocate for improvement. In this report, we focus on compulsory community treatment orders (CCTOs) made under section 29 of the [Mental Health \(Compulsory Assessment and Treatment\) Act 1992](#) (Mental Health Act). These orders enable clinicians to compel people (tāngata whaiora) who are living in the community to be treated, typically with medication, without their consent. In [Te Huringa 2022](#), we called for action from services to ‘maximise autonomy and uphold rights’ of tāngata whaiora (Mental Health and Wellbeing Commission, 2022). [Te Huringa Tuarua 2023](#) continues this call for change (Te Huringa Mahara, 2023).

Given the important work under way to replace the Mental Health Act, now is a critical time to hear tāngata whaiora perceptions of current practices in CCTO use and what matters most to them. While operating within the legal parameters of the Mental Health Act, services need to be supported in continuing efforts to improve practices that move us from coercive treatment to choice-based treatment in mental health and addiction services.

Purpose and scope

The purpose of this report is to shine a light on the use of CCTOs in practice, by amplifying the voices of those with experience of compulsory treatment in the community. We seek to influence services change practices now, in readiness for new legislation, based on supported decision making and Te Tiriti o Waitangi.

In line with our legislative function, we intentionally focus on tāngata whaiora perceptions of CCTO processes and practices. We identify the clinical review and the court hearing as formal substitute decision-making processes under the Mental Health Act. These processes translate to CCTO applications and outcomes that Manatū Hauora reports publicly. These events take place daily in Aotearoa across a range of service contexts. The perceptions and experiences of mental health and legal professionals with formal roles under the current Mental Health Act are also important for understanding what influences CCTO use in practice; however, these voices are not the focus of this report.

The topic of compulsory treatment in mental health and addiction systems raises complex legal and ethical issues. We acknowledge the extremely close connections between the use of CCTOs, access to treatment provided by services, and what options are currently available and funded within services.

The Mental Health Act created compulsory community treatment orders

They've got the medical model and the court model involved in this, but where's the whānau in this? - Māori focus group

In the early 1990s, more than 30 years ago, the Mental Health Act formalised CCTOs as a legal mechanism to extend hospital-based treatment to 'outpatients' and require their recall as 'inpatients',¹ on the basis of a new legal definition of 'mental disorder' (O'Brien et al, 2009).² The Mental Health Act needed to fit the new structure for service delivery that was under development while the older psychiatric hospitals were closing. In the context of this deinstitutionalisation, the aim of introducing CCTOs was to give 'outpatients' greater freedom and protection of rights than they had when detained in hospital under previous legislation.³ The Mental Health Act enacted 'patient rights' and an obligation to exercise powers with 'proper recognition' of a person's ties with their family, whānau, hapū, and iwi. Measures to protect those rights included establishing the independent district inspector role to investigate patient complaints, along with formal review and appeal procedures to challenge compulsory status by applying to district courts and the Mental Health Review Tribunal.

While the Mental Health Act was an improvement on previous legislation, it does not comply with current international human rights obligations in Aotearoa.⁴ A significant issue is that the Mental Health Act can override a person's right to refuse medical treatment in the New Zealand Bill of Rights Act 1990. Under the Mental Health Act, decisions to use compulsory treatment orders are not required to consider whether tāngata whaiora have the decision-making skills to consent, or refuse, treatment. This

¹ This language might reflect the 1969 Act under which people were routinely recalled to hospital after two years for an overnight stay and then discharged as 'on inpatient leave' (A O'Brien, personal communication, April 2023).

² The Mental Health Act defines mental disorder in section 2 as '... an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it: (a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself.' These 'mental disorder' entry and exit criteria under the Mental Health Act align with access to and discharge from acute hospital-based services.

³ Under the Mental Health Act, section 28(4) states, 'Before the court makes a community treatment order, it must be satisfied ... that the service provides care and treatment on an outpatient basis that is appropriate to the needs of the patient.'

⁴ The [United Nations Convention on the Rights of Persons with Disabilities](#) requires States to replace substitute decision-making regimes with supported decision-making regimes. Under the Mental Health Act, clinicians and courts substitute decisions of tāngata whaiora, instead of support decisions based on tāngata whaiora will and preferences.

is contrary to other health and disability rights, where a person is presumed ‘competent’ to make decisions about their treatment.⁵ The Committee of the Convention on the Rights of Persons with Disabilities has commented that a person’s core human right to equal recognition before the law means their disability/diagnosis and decision-making skills (as clinical assessment of their mental capacity) cannot be grounds for lowering their status as a person before the law, but requires that support to be provided in their exercise of legal capacity (Committee on the Rights of Persons with Disabilities, 2014). Working to the detriment of a focus on rights, assessment of risk has dominated the approach to applying the Mental Health Act, as required by the Mental Health Act’s definition of ‘mental disorder’. Despite evidence to the contrary, the ‘mental disorder’ definition promotes a prejudiced perception that mental illness diagnoses are inherently linked to dangerous behaviour (Simpson et al, 2004). This definition also implies that clinical risk assessment can predict outcomes, including future harmful behaviour.

In the language of the Mental Health Act, ‘mental disorder’ combines ‘an abnormal state of mind’ with ‘serious danger to self or others’ or ‘seriously diminishes capacity for self-care’. A ‘responsible clinician’ who is ‘in charge of treatment’ and a court have legal authority to substitute a decision that a person might otherwise make about their treatment on the grounds that the person is ‘mentally disordered’. A clinical review⁶ involves a clinician’s assessment of ‘mental disorder’ and requires consultation with whānau and family.⁷ A clinician’s opinion that a tangata whaiora ‘is not fit to be released’ from compulsory status leads to an application for compulsory treatment to the Family Court.⁸

A court hearing provides independent oversight by a judge. Tangata whaiora are entitled to legal representation. A judge must consider the ‘patient’ view, and consult with the responsible clinician in charge of treatment and at least one other ‘health professional’. A judge may also consult with any other people concerning the ‘patient’s condition’.

The simple infographic that follows shows how clinical review and hearing events are part of the current Mental Health Act procedure that can make tangata whaiora subject to CCTOs. It is important to note that at any time between these formal events, the ‘responsible clinician’ can decide to release a ‘patient’ from compulsory status if the clinician’s opinion is the patient is no longer mentally disordered.

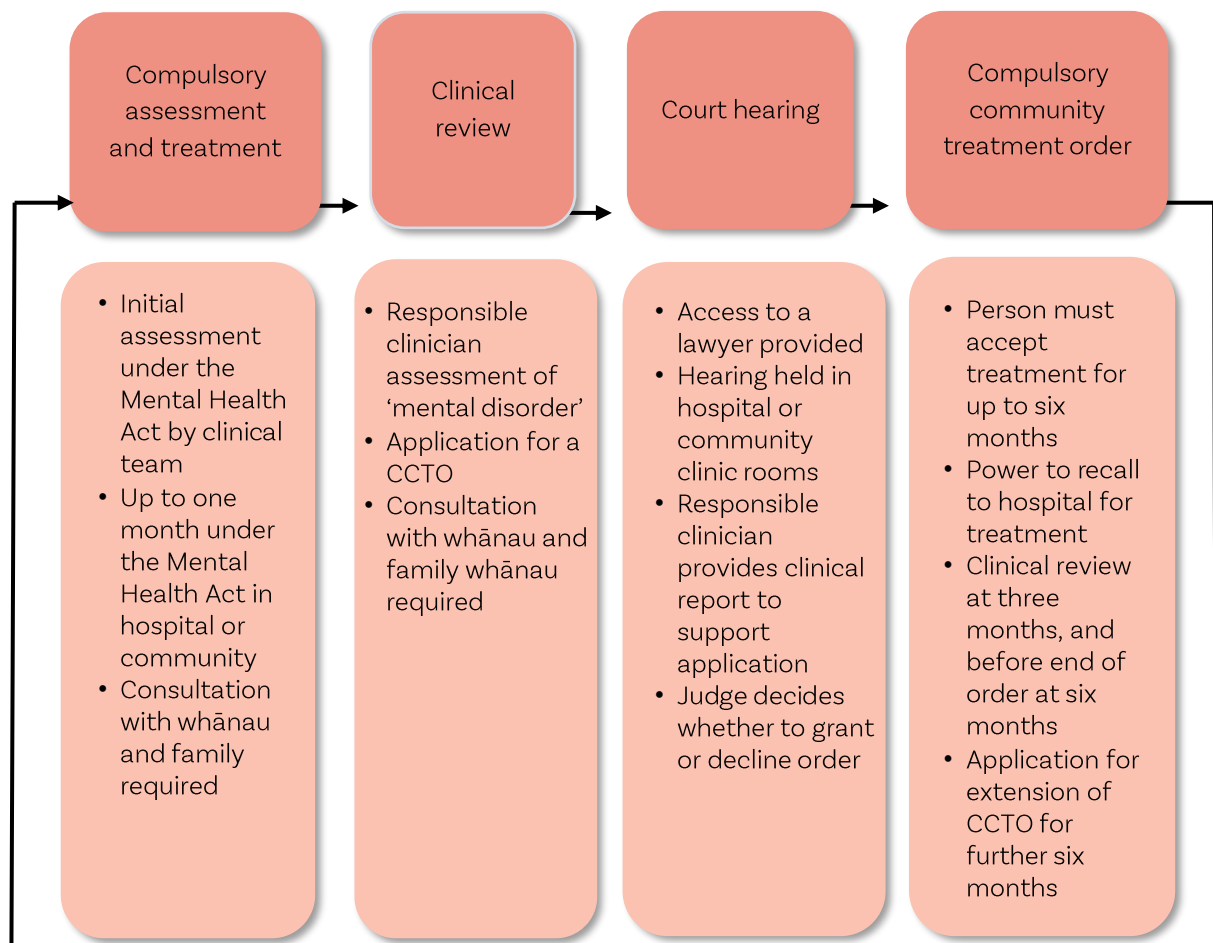
⁵ For example, see section 5 of the [Protection of Personal and Property Rights Act 1988](#) and right 7(2) of the [Code of Health and Disability Services Consumers’ Rights 1996](#).

⁶ Section 76, Mental Health Act.

⁷ Section 7A, 1999 amendment to the Mental Health Act.

⁸ Section 28(1) provides that every compulsory treatment order must be a community treatment order or an inpatient order.

Stages of clinical review and court hearing in CCTO process



What it means to be under a compulsory community treatment order

It's such a fundamentally disempowering... process... where you're being forced to do something that you don't want to do. - Lived experience focus group

So often it seems to me that the decision's already been made... the judge's doctor has already formed the opinion. It's pretty much just a kind of rubber-stamping situation which seems like, for the impact it has on the person, really unfair. - Lived experience focus group

If a court grants a CCTO, the CCTO gives authority to the responsible clinician in charge of treatment, who is typically but not always a psychiatrist, to direct the treatment of a tangata whaiora. This means it is legal to override the usual requirement for services to obtain the person's consent to treat them. Treatment can include a range of therapeutic interventions that the tangata whaiora consents to, such as talking therapies. In practice, the treatment intervention that is compulsory

under a CCTO is prescribed medication for psychiatric illnesses⁹ administered as tablets or long-acting intra-muscular injections (IMIs). Typically nurses provide this medication at a community clinic or at a place where the tangata whaiora lives or works in their community. A CCTO requires the person to attend at their place of residence, or at some other place named in the order, for treatment by a specified service, and to accept that treatment. This sometimes involves a clinician entering the person's home to monitor oral medication or administer IMIs. Where the person declines the medication, sometimes a service seeks help from the police to readmit the person to hospital so that staff can administer the medication.

Compulsion of any kind, I mean if there's any situation where we are having to force someone to do something that they don't want to do, I think regardless of everything that is wrapped around that, that has to be considered a failure... of communication and planning in the way we navigate conflict. - Lived experience focus group

The initial CCTO lasts for up to six months. It includes a requirement for a clinical review of the tangata whaiora every three months, which can result in a decision to either discontinue or continue compulsory treatment. The responsible clinician can apply to court to extend the CCTO for a further six months, then reapply for a further 12-month period.¹⁰ Under the Mental Health Act, it is the decision of the judge whether to grant, or refuse, the order. Compulsory community treatment has become embedded in the structure of mental health services in Aotearoa.

Government action on He Ara Oranga recommendations

[He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction](#) (He Ara Oranga) made two key recommendations relevant to use of CCTOs (Government Inquiry into Mental Health and Addiction, 2018). These are recommendations 34 and 35, and the Government accepted both of them in 2019. Recommendation 34 called for repealing the Mental Health Act and replacing it with a law that better reflects Crown obligations in Aotearoa under Te Tiriti o Waitangi and international commitments under the United Nations Convention on the Rights of

⁹ 'Patients treated under compulsory treatment are more likely to be male and socio-demographically deprived with a diagnosis of schizophrenia, non-affective psychosis or mood disorder, although compulsory treatment is initiated when medico-legal criteria are met and potential patient diagnoses cover the full breadth of psychiatry' (Beaglehole et al, 2021, p. 2).

¹⁰ See [Āpitihanga tuatahi: Te tikanga hei arotake i ngā maimoatanga ā-hapori whakature](#) | Appendix one: The process of reviewing CCTOs.

Persons with Disabilities.¹¹ Recommendation 35 called for a national conversation about mental health and risk.¹² He Ara Oranga acknowledged that ‘legislative change on its own will not drive systemic change’ and that it needs to be supported with best practice that promotes supported decision making and provides measures to minimise compulsory or coercive treatment (Government Inquiry into Mental Health and Addiction, 2018).

We comment briefly on action in response to these recommendations.

Towards repealing and replacing the Mental Health Act 1992

In 2020, Manatū Hauora updated best practice [guidelines on the Mental Health Act](#) and provided guidance on a rights-based approach aligned with Te Tiriti o Waitangi, including guidance on supported decision making that recognises the will and preferences of tāngata whaiora (Ministry of Health, 2022a). The companion document to these guidelines, [Human Rights and the Mental Health \(Compulsory Assessment and Treatment\) Act 1992](#), ‘provides guidance on how to think about and apply human rights, recovery approaches and supported decision making when implementing the current Mental Health Act’ (Ministry of Health, 2020).

Manatū Hauora completed public consultation on [Transforming our mental health law](#) and released an [analysis of submissions](#) in May 2022 (Ministry of Health, 2021, 2022b). Among ‘stakeholders’ that called for removal of compulsory treatment from legislation, some viewed removal as ‘aspirational’ in the sense that it is not possible with our current design and focus of services. These views reinforce the necessity of redesigning services to achieve the transformation people are seeking. There was consensus among the submitters that legislation should advance supported decision making as a means of empowering tāngata whaiora, upholding their rights, and following their wishes (Ministry of Health, 2022b). The policy to inform the new legislation is under development. Once the Government has agreed to the policy for new legislation, a Bill will be created that will go through the Parliamentary processes (Manatū Hauora, 2022).

¹¹ Recommendation 34 states: ‘Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights-based approach, promotes supported decision making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment.’

¹² Recommendation 35 states: ‘Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB [district health board] chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health and Quality Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.’

In the meantime, the Government amendment to the Mental Health Act to eliminate ‘indefinite orders’ will come into effect on 29 October 2023.¹³ For any compulsory treatment orders to continue, a six-monthly clinical review must occur and it is only possible to extend any of those orders through a judge. Eliminating indefinite CCTOs in law is a positive step forward because it provides certainty about the duration of orders and increases administrative and judicial oversight.

Changing attitudes to risk and mental health

In December 2022, Manatū Hauora released a [discussion paper](#) on reviewing risk and mental health in terms of safety and opportunity, as one aspect of re-examining our beliefs and attitudes (Changem Ltd, 2022). The purpose of this discussion paper was to support a national conversation about risk. As noted in He Ara Oranga:

... shame and stigma shape attitudes and act as barriers to seeking help. The Mental Health Act embeds archaic and risk-averse attitudes that cause clinicians to opt too readily for coercion and control. (Government Inquiry into Mental Health and Addiction, 2018, p. 10)

Mental health clinicians face the responsibility of responding to complex needs in the current service context of limited options and a stretched workforce.

In [Te Huringa 2022](#), we called for support for services to develop positive risk-taking approaches (Mental Health and Wellbeing Commission, 2022). Public attitudes towards risk and mental health are important to support the transformation in how we approach mental wellbeing in Aotearoa. For this reason, we need to engage the public in the conversation about mental health and risk as a way of building support for the changes in practice we want to see. For tāngata whaiora, a broader question concerns fairness and social inclusion, particularly for tāngata whaiora Māori and Pacific peoples (Aikman, 2022).

¹³ Amendment Bill passed in October 2021. The commencement date for this new provision is 29 October 2023. Under the Mental Health Amendment Act 2021, indefinite compulsory treatment orders (CTOs) will be eliminated and will be replaced with a requirement for a 12-month extension (s 34A), when a CTO has already been extended once under section 34(2) of the Act. If following that section 76 review, the responsible clinician is of the opinion that the patient is not fit to be released from compulsory status, the responsible clinician will then be required to apply to the Family Court for extensions under the provisions of section 34A for new 12-month indefinite CTOs (Ministry of Health, 2022a, pp. 73–4).

Ngā tikanga maimoatanga ā-hapori whakature | Compulsory community treatment in practice

Te Whatu Ora—Health New Zealand (Te Whatu Ora) mental health services (formerly services in district health boards (DHBs) collate data on their use of compulsory assessment and treatment under the Mental Health Act, which Manatū Hauora reports each year. In addition, Te Tāhū o te Ture—Ministry of Justice (Te Tāhū o te Ture) collects data on applications and orders, which Manatū Hauora refers to in its reports. Most quantitative data we use in this report are from Manatū Hauora. However, we sourced the 2021/22 data on applications and CCTO outcomes from Te Tāhū o te Ture. Where relevant, we highlight which of these sources we used in the context of our analysis.

The use of CCTOs is increasing and varies considerably across districts

For the year from 1 July 2020 to 30 June 2021, the Office of the Director of Mental Health and Addiction Services reported that 6,817 people were under CCTOs. On a given day in that year, the average number of people under a CCTO was 4,608, which equates to 90 people per 100,000 population. This finding indicates that use of CCTOs increased over five years: in 2017, 4,259 people were subject to CCTOs on an average day, or 88 people per 100,000 population (Ministry of Health, 2019).¹⁴

Overall, ethnicity figures show persistent inequity for Māori and Pacific peoples. In 2020/21, the rate of people subject to a CCTO was 307.3 per 100,000 population for Māori, 182.9 for Pacific peoples and 89.8 for other ethnicities (Ministry of Health, 2022c, p. 10). Māori were 1.8 times more likely than Pacific peoples and 4.0 times more likely than other ethnicities to be subject to CCTOs. Moreover, while the number of people subject to CCTOs is increasing overall, the number of Māori subject to CCTOs is increasing at a faster rate—by 13 per cent from 2018 to 2020/21 compared with 5.8 per cent for non-Māori, non-Pacific peoples (Te Hiringa Mahara, 2023, p. 42).

Furthermore, districts vary considerably in their rates for Māori, Pacific peoples, and other ethnicities subject to CCTOs. Manatū Hauora states that explaining this variation requires ‘in-depth, area-specific knowledge to understand why differences

¹⁴ We note that Aotearoa CCTO rates are high by international standards. The increasing trend is also evident over a longer period: when these rates first reported in 2005, 60 people per 100,000 population were under a CCTO. See also O’Brien (2014).

occur in each DHB region and how to address them at a local level' (Ministry of Health, 2022c, p. 11).

In addition, overall rates of CCTOs vary significantly between districts, from 48 per 100,000 population in Bay of Plenty to 181 per 100,000 population in Hawke's Bay in 2020/21 (Ministry of Health 2022c; see also *Āpitihanga tuarua: Te tau tāngata kei raro i ngā maimoatanga ā-hapori whakature ā rohe* | Appendix two: Average number of people under CCTOs by district). While contextual factors will help to explain this variation, the low rates of CCTOs in some districts warrants further investigation. There is no evidence to indicate that these districts are less successful in responding to tāngata whaiora needs without the use of court orders. Higher rates of CCTOs are also associated with regions of high social deprivation. Aotearoa research has found high use of CCTOs in certain geographical areas, among populations marginalised in relation to social deprivation and ethnicity (O'Brien, 2013). However, social deprivation and ethnicity does not fully explain the district variation in CCTO use. This means other factors specific to services in each area, such as workforce and options for support in the community, are also influencing CCTO use in practice.

Consultation with whānau and family is an important requirement under section 7A, introduced in the 1999 amendment to the Mental Health Act. Data reported on section 7A in 2020/21 showed that whānau and family consultation happened on average 74.7 per cent of the time for first applications but dropped to 58.8 per cent for clinical reviews required under compulsory treatment orders and extensions (Ministry of Health, 2022c). The section 7A data from Manatū Hauora are not only for CCTOs—they also include clinical reviews and first applications for other types of compulsory treatment orders, for example compulsory inpatient treatment orders.

Over the last five years, the courts consistently granted 88–89 per cent of all applications made. Of all applications granted in 2021/22, 3,031, or 56 per cent, were CCTOs. We note that there is a slight difference in the data reported by Manatū Hauora (Ministry of Health, 2022c) and the data provided by Te Tāhū o te Ture. This difference is explained by the date of data extraction: Manatū Hauora extracted its data for 2020/21 on 9 May 2022 from Te Tāhū o te Ture Case Management System, which is a live operational database, whereas the data Te Tāhū o te Ture provided to Te Hiringa Mahara were extracted on 11 January 2023.

Despite the complexity of issues, there is little published research in Aotearoa on the use of CCTOs.¹⁵ However, an increasing body of international research, including in Australia, focuses on uncovering the complexity of issues associated with CCTOs and contributing to evidence-informed policy and practice that comply with human rights (Brophy et al, 2021).

¹⁵ We note the Otago CCTO Study in the early 2000s explored stakeholder perspectives of CCTOs, including factors influencing responsible clinicians use of CCTOs (Dawson, 2007).

Studies reinforce that CCTOs have limited, if any, clinical effectiveness

To give context to the quantitative data above, this section comments on research into the effectiveness of CCTOs, which typically focuses on inpatient readmission rates. We also refer to research into the experiences of people involved in CCTO use.

CCTOs are contentious because their use raises human rights, ethical and social issues. We found no international research to support an argument that they are clinically effective or have therapeutic benefits to justify their use to the extent that they can override human rights (Kisely et al, 2021).¹⁶ In this context, studies tend to measure clinical effectiveness in terms of rates of hospital admissions and length of hospital stays in CCTO and non-CCTO populations. An Australian study examined data on service use as a measure of effectiveness, found that the length of CCTOs reduced after change in the law to make it more consistent with human rights. It also found the number of inpatient orders increased, raising questions about the effectiveness of the available community services and treatment in the absence of compulsion (Vine et al, 2019). Any therapeutic benefits to individuals can be associated with increased contact with services, rather than with the CCTO itself (Beaglehole et al, 2021). Conversely, evidence indicates that compulsory community treatment is clinically harmful—the threat and use of coercion, enabled by law, undermine beneficial and therapeutic relationships based on trust. If research defines the effectiveness of CCTOs in terms of reduced rates of admissions to hospitals, it would overlook evidence of adverse impacts that come from maintaining use of antipsychotics (Dorozenko and Martin, 2017).

A recent study in Aotearoa established a link between increasing use of CCTOs and increasing dispensing of antipsychotics (Beaglehole et al, 2021).¹⁷ For psychotic disorders, CCTOs were associated with reduced admission frequency and duration. However, the opposite occurred for dementia disorders, bipolar disorders, major depressive disorder, and personality disorders. The authors suggest that the role of CCTOs should be questioned for patients without psychotic disorders (Beaglehole et al, 2021, p. 8).

Of critical concern, the study found CCTOs were associated with increased dispensing of medications associated with CCTOs, including depot (slow-release injection) antipsychotic medications, for tāngata whaiora in all diagnostic groups (see also Te Huringa Mahara, 2023). Of equal concern, given the inequity in CCTO rates, is whether services for tāngata whaiora under CCTOs recognise the importance of

¹⁶ See also the [Oxford Compulsory Treatment Evaluation Trial \(OCTET\) study and follow up](#) that found no obvious clinical benefit to justify restricting people's liberty to such a degree (Rugkasa et al, 2017).

¹⁷ Researchers used Ministry of Health demographic, service use, and medication-dispensing data for all individuals placed on a CCTO between 2009 and 2018 (Beaglehole et al, 2021).

cultural perspectives in diagnostic assessment (for example, see Taitimu et al, 2018) and of discussing medication as treatment with tāngata whaiora.

Māori psychiatrists Hinemoa Elder and Rees Tapsell have long called for cultural assessment and for Māori to undertake more research to understand the disparity in rates between Māori and non-Māori:

Our analysis suggests that improved and consistent training, and a focus on the cultural formulation, are critical components of a culturally valid psychiatric opinion and therefore of its quality regarding the presence of ‘mental disorder’. (Elder and Tapsell, 2013, p. 263)

They suggest that cultural workers, speakers of te Reo Māori who are proficient in tikanga, are essential to ensuring the validity of the cultural formulation and providing culturally informed processes of assessment, including by informing decisions about the use of the Mental Health Act (Elder and Tapsell, 2013).

Studies reinforce that experiences of CCTOs are not therapeutic

CCTOs have been referred to as ‘leash laws’ from the perspective of those subject to them (Boudreau and Lambert, 1993, p. 71). A recent discussion paper from the Mental Health Foundation of New Zealand includes an overview of interview-based studies on how service users, practitioners, and families see CCTO use in Aotearoa and elsewhere. The authors found it is rare for research exploring the experiences of CCTOs to be undertaken by or with people with experience of being under compulsory treatment, particularly tāngata whaiora Māori and Pacific peoples (Schneller et al, 2022). Studies that explore compulsory community treatment from the perspectives of service users, family, and mental health practitioners refer to participants as ‘stakeholders’ and show the treatment has little, if any, therapeutic benefit because it undermines service users’ trust in treatment relationships and services, in turn increasing their harm and trauma in the long term. Compulsory treatment further marginalises particular groups in society and increases inequity for indigenous and non-white ethnicities. The authors concluded that international studies involving multiple ‘stakeholder’ perspectives tend to focus on ways of improving the experiences of compulsory treatment, rather than on how to avoid its use.

We consider an important insight into what is at stake comes from exploring the question of whose knowledge gets privileged in designing and producing the research that provides the evidence that then guides the transformation of our mental health and addiction system.

Avoiding compulsory treatment of any kind that currently exists under the Mental Health Act involves shifting law and practice from substitute to supported decision making, as Manatū Hauora recognises in its best practice guidelines on the Mental

Health Act (Ministry of Health, 2022a). Interventions that facilitate supported decision making in the cultural context of Aotearoa were the focus of a recent study involving perspectives from practitioners, communities, and service users (Gordon et al, 2022). Findings pointed to the effectiveness of proactive pre-event planning and post-event debriefing. Positive conditions and support for making decisions included enabling options and choices and providing information and education. Research participants from groups that commonly experienced inequities prioritised easily accessible options. The study has implications for supported decision making in practice, suggesting that people, place, time, and material resources are all essential to regular reviews and reflection.

We also acknowledge that the Law Commission | Te Aka Matua o te Ture is reviewing our current framework governing adult decision-making capacity laws. It will consider the implications of its work for the current review of the Mental Health Act by Manatū Hauora (Te Aka Matua o te Ture | Law Commission, 2022).

Ngā reo o ngā tāngata whaiora me ngā whānau | Tāngata whaiora and whānau voices

We held three focus groups to hear the views of people with lived experience—including Māori, tāngata whaiora, whānau, and family—about the use of CCTOs. During the group discussions, participants reflected on their involvement in clinical reviews and court hearings as major decision events in the CCTO process under the Mental Health Act.¹⁸

In this section, first, we highlight some of the experiences tāngata whaiora, whānau, and family had that led them to feel physically excluded from review and hearing processes. A second theme calls out ways that these decision-making events silence or override their perspectives, including perspectives from Te Ao Māori. The examples of exclusion and marginalisation illustrate the extent to which some practices need to change before tāngata whaiora and whānau can be leading decisions on their own care and treatment, with support if needed. A third theme focuses on what we heard can be done now, under the current Mental Health Act, to improve practices in ways that protect mana and uphold rights to the greatest extent possible, before the new law embeds Te Tiriti o Waitangi and international human rights in services for tāngata whaiora. A fourth theme highlights other negative perceptions of CCTO use.

Tāngata whaiora and whānau feel excluded from clinical reviews and court hearings

Tāngata whaiora potentially could receive useful and meaningful support from, for example, non-governmental organisation (NGO) support services, general practitioners, cultural experts (Māori and non-Māori), whānau, and/or family. Yet tāngata whaiora highlighted how opportunities for such supporters to attend and participate in both clinical reviews and court hearings were limited. Similarly, whānau emphasised that “who attends hearings is important” and often staff that do participate “lack cultural competency or cultural understanding.”

Participants spoke of a lack of timely communication and sharing of information ahead of these planned processes. As a result, support providers, whānau, and family had no opportunity to make the travel and work arrangements they needed to in order to attend. “People don’t get time to prepare, get an advocate, get familiar with

¹⁸ For details on our methods for engaging with participants, facilitating focus groups, and analysing qualitative data from the groups, see [Āpitianga tuatoru | Appendix three: Project design and methods for qualitative analysis](#).

the process” and the example was given of “meeting five minutes before the hearing being asked by the lawyer, so what do you want?”

Relevant to the requirement for consultation with whānau and family under section 7A, we heard that whānau and family are often not consulted at all, with the result that they feel overlooked and helpless. Whānau and family spoke of being left out of these processes completely:

There was no processes for involving families from the start. - Whānau focus group

Whānau and family commented on how they were confused about the process generally, such as staff roles, the meaning of the terms clinicians used, and where and how to access support. They also experienced exclusion from discharge planning when tāngata whaiora were leaving hospital to continue with treatment in the community. In instances where whānau and family are consulted, they spoke of their frustration at not being included in decision making. We heard that “it’s exhausting having to repeat yourself,” which suggests one-way information sharing and a narrow application of section 7A consultation in practice (see section 7A data in the [previous section](#)). Whānau and family feel the process excludes their knowledge of the person and they want education to help them support tāngata whaiora.

We heard that clinicians’ use of specialist terms both when speaking and in clinical notes and reports excludes, and limits participation of, tāngata whaiora as well as whānau and family:

Clinical language does not translate to whānau and whaiora well. So, how can they be involved in planning when they don’t understand what’s being said to them. - Māori focus group

Focus group participants emphasised that the information about these processes is rarely available in plain language, either in English or in other languages. As a result, it is difficult for tāngata whaiora and whānau to advocate from their lived experience and whānau perspectives.

We were especially concerned to hear that tāngata whaiora do not get access to clinical reports for the application and important evidence for the hearing:

Everyone has seen the report but the patient or service user... you go into the room a bit disadvantaged because everyone has more information than you do. - Lived experience focus group

Tāngata whaiora did not experience the process as an opportunity for their views to be heard at all:

The doctor has already formed the opinion. It's pretty much just kind of a rubber-stamping situation. - Lived experience focus group

The doctor's the 'official opinion' and so, the judge follows what the doctor says. - Lived experience focus group

We heard that the “current process is disheartening as it's bargaining a person's hauora and their wish to stop medication.” Tāngata whaiora experience the court process as adversarial: “going before a judge makes people feel like they're bad or have committed a crime.” These feelings are amplified with court security in attendance. Tāngata whaiora spoke of a process that continues to criminalise whānau: “what law have we broken to come before a judge?” The court process itself reinforces social exclusion for tāngata whaiora:

... we are treated as second rate citizens. - Māori focus group

Participants saw the places where the court hearings are currently held, such as inpatient units, as inappropriate. They acknowledged that new or upgraded buildings in hospital settings provide spaces that are better for the hearings. However, such places generally have insufficient seating, and their waiting areas are not suitable for private conversations with lawyers and clinicians. Tāngata whaiora and whānau spoke of these physical spaces as “not welcoming” for whānau and the lack of manaaki they experienced.

We also heard that the attitude of those conducting the process is even more important than the venue. Māori have found that a tikanga process—in which, for example, “judges speak Māori, they're welcoming, invite whānau input”—is beneficial.

Clinical reviews and court hearings marginalise Te Ao Māori and lived experience perspectives

We heard that currently processes under the Mental Health Act do little to follow or include Te Tiriti o Waitangi and Te Ao Māori worldview.

Cultural assessment is more important than medical assessment, even the most important for Māori, in the Mental Health Act process. - Māori focus group

A participant gave the example of using pūrākau¹⁹ as an important way of “determining what the whānau is actually carrying.” Because the legal process does not actively provide for cultural assessment and input, it “diminishes the mana as a whānau member.” Consistent with the way they physically exclude whānau, as described above, the clinical assessment reviews and hearings are not focused on collective approaches to decision making that resonate with Te Ao Māori.

From a systems perspective, all districts have high rates of use of CCTOs for Māori men—we heard that this overuse of the Mental Health Act is a form of institutional racism (see also McMeeking et al, 2022). Services rely too heavily on pharmaceuticals, which has a disproportionate negative impact on tāngata whaiora Māori and Pacific peoples:

Medication affects Māori and Pacific in very different ways... it increases the possibility of diabetes, coronary heart disease, heart failure, renal failure. - Māori focus group

We heard that clinical review and hearing processes marginalise the perspectives of tāngata whaiora, whānau, family, and Māori. Tāngata whaiora and whānau feel their concerns and wishes are not heard. They commented on how clinicians do not recognise “individual people and causes of trauma that are all so different for everyone.” In clinical assessment processes, as one participant described it, “people are put in the same box—we have to think outside the box.”

Tāngata whaiora as well as whānau and family agreed that:

I tend to see it as an and, because western medicine has its place. So does other ways of being. There is no two ways about that. - Whānau focus group

However, we heard discussion rarely occurs with tāngata whaiora to plan the kinds of support they prefer. Instead, current processes prioritise medication in decisions made for (not by) them about their treatment.

Focus group participants spoke of compounding issues for tāngata whaiora, such as having insufficient information on medication side effects, strategies, and practical support:

It can be a decades-long process of... trying different medications. ... the long-term impact of those medications, for example, olanzapine can be really, really,

¹⁹ We understand pūrākau to mean storytelling, as an ancient form of transmitting ideas and creating shared meaning and identity (Stansfield, 2020).

really, hard to get off and can be really destabilising when you try and get off it... Informed consent there is lacking. - Lived experience focus group

Participants found the lack of information on medications and side effects concerning when “it’s such a huge impact on your life.” Medication is being forced on tāngata whaiora without “the other things that might support wellbeing”. Tāngata whaiora spoke of a “fundamentally disempowering” structure that required them to keep with the plan, rather than enable them to challenge it as they might do if they had more information. Both clinical reviews and hearings have insufficient time for discussion related to medication concerns.

We heard from tāngata whaiora as well as whānau and family how decision making privileges psychiatric and medical experts and expertise:

Psychiatrists should only offer an opinion, but it should not be law that only their perspective is honoured - Māori focus group

The judge in doing that has gave power and mana over to the lawyer, didn’t validate the whai ora and their aspirations... It was a takahi on the whai ora... it is not giving any of the power and control to the whai ora to say what their moemoeā is...not strengths based. - Māori focus group

We also heard that when tāngata whaiora do raise their concerns, “feelings around shame and hopelessness that come from being under a CCTO are mistaken for symptoms.” Excluding perspectives from CCTO processes, as those described in the examples above, has wider implications for the system and raises particular concerns about how CCTOs are used in practice.

Because the processes do not hear or honour their concerns and wishes, tāngata whaiora spoke of those processes in terms of “cloak and dagger.” The metaphor reflects the painful experience of trusting in current practices and then being stabbed in the back, which the following comment also illustrates:

If you wouldn’t say it to my face, don’t write it in my notes. - Lived experience focus group

Cultural and clinical practices need to improve in ways that uphold rights

Participants called for placing supported decision making at the centre of the new law. This is very important and distinct from current consultative approaches. Tāngata whaiora as well as whānau and family are often left out of planning and decision-making processes that need to be led by them if those processes are to improve.

Whatever the whānau says should be what we are moving towards. ... [This should] drive all the services that we provide. - Māori focus group

Supported decision making requires more discussion and more time for decision making, and means the “entire process needs slowing down.” We note that this call resonates with a key finding in an exploratory study on supported decision making in Aotearoa, which we described in the [previous section](#) (Gordon et al, 2022).

Tāngata whaiora described the effects of having limited, or no, time for discussion in clinical reviews and hearings; time to listen to tāngata whaiora as well as whānau and family; and hear about the support they are seeking. Tāngata whaiora wanted to see more collaborative, trust-based discussions and negotiation to enable people, with support if they needed it, to make decisions when not in crisis—so services are “not making decisions about us without us.”

We heard that “lots more information needs to be provided about rights.” Tāngata whaiora, whānau, and family need information in plain language so that they can engage in better advocacy. Emphasis on ‘rights’ is on the person’s entry to the Mental Health Act and on making an order, but far less attention is paid to the person’s exit, or getting ‘taken off’ the CCTO, including proactive support to do so:

If somebody has been on medication for several years and they want to try coming off it, then we should actually support them with that, and currently we don’t. - Lived experience focus group

When tāngata whaiora want to come off their medication, they should have more information and practical support, such as calls and reminders, to enable them to follow a plan to do so.

Where tāngata whaiora have beneficial and supportive relationships with their clinicians, there is no need for CCTOs. Those kinds of relationships, participants said, involved more discussion and collaboration with tāngata whaiora—more plain language information, no ‘pushback’, more use of advance directives as a tool, and no

‘cloak and dagger’ surprises. We heard that innovative approaches can be built on trust.

If you could have that good relationship from the beginning, there would never be any need for a community treatment order... because it would be a collaborative agreement about what was happening next. - Lived experience focus group

For whānau, the vision is to have more safe places for care and respite, other than hospitals. Participants emphasised the frustration and fear they felt in supporting tāngata whaiora as “normal reactions” that are common to physical and mental health events people experience in life. They had strong views on the need for more of the right kind of support, advice, and information to participate in the process.

An increase in support and advocacy more broadly is needed, such as peer support and after-discharge support, as well as support in clinic waiting rooms following IMI, and leading up to and in the court hearings. Cultural peer workers and those in NGOs or community groups also need to be involved. For example, we heard from tāngata whaiora that “NGOs should have standing to come in and advocate for the person in court hearings.”

We also heard how the concept of ‘court’ suggests tāngata whaiora are criminals rather than seeking pae ora, pathways to wellness.

Did our whānau do something wrong? Did they break a [law] to have to go to court, could it be something else other than a court?. - Māori focus group

Tāngata whaiora Māori spoke of the need for a new name for this process that is restorative and acknowledges trauma and pain that is more than ‘mental illness’, because the current process “doesn’t sing hauora, oranga, pae ora.” They want the process to be conducted in an environment that is conducive to wellbeing.

The new law and processes need to be co-designed with Māori. To participants, this means developing a system that is “tikanga and kawa driven through co-design that honours Te Tiriti and can be different in each region” and that privileges and “upholds mana of the guest, not a rigid way of viewing things.” Mental health services should be more like physical health services for tāngata whaiora living in community in that “I still get to choose my medication.” A more collective approach is needed in which “everyone in the room who the person wants there” and clinicians must follow a supported decision-making process.

Focus group participants imagined collaborative community support approaches that are more focused on prevention and choice-based, where people can build trust without the threat of legal coercion.

Other negative experiences of CCTO use

Tāngata whaiora, whānau, and family described how the Mental Health Act is used ‘aggressively’ as a justification for treatment without explaining what it involves, specifically in relation to CCTOs.

I’ve heard from many people that compulsory community treatment is used as a weapon at times and if you are under a depot or an IMI, they say, ‘If you don’t have this, we’ll send you back to hospital’. It is kind of like a way of them taking power and taking all the control off you, and I think it’s completely unfair to manipulate people like that.
- Lived experience focus group

Where clinicians use a CCTO to threaten readmission by force, it further undermines trust and beneficial relationships. We also heard about how clinicians used CCTOs as a tool for whānau and family to access assessment and treatment, encouraging them to initiate the Mental Health Act for this purpose.²⁰

Where whānau and family gave limited support to CCTOs, they framed their reasons in terms of the inadequacy of the services available.

To get the support [that’s] needed... we have no choice but to do things like that. - Whānau focus group

They considered CCTOs are sometimes needed as means of coercion so loved ones take medication. However, they also recognised medication has negative effects—“it made them a zombie”—along with positive effects, such as “it helped level the person when too unwell to make informed decisions.” Whānau and family did not want their loved ones on the CCTO long term, but also spoke of how hard it is to get off a CCTO. We also heard that “a discharge from CCTO leads to a belief they [tāngata whaiora] don’t need to be on medication any longer.” We are concerned to hear of the perception that an ongoing need for medication as part of treatment is inseparable from CCTO status. As tāngata whaiora, whānau, and family see it, support and treatment depend on the continued CCTO use under the Mental Health Act. That is, they believe that tāngata whaiora may have reduced access to services if they are not under the Mental Health Act.

²⁰ Clinicians and family see the use of the Mental Health Act as a way of accessing acute services (A O’Brien, personal communication, April 2023).

In summary, participants in our focus groups agreed that tāngata whaiora experienced injustice and harm with compulsory treatment in the community. Overall, they described CCTOs in practice as barriers to tāngata whaiora establishing trusting, collaborative relationships with services, where beneficial relationships are essential to support tāngata whaiora-led recovery. However, participants also spoke of what can be done differently under the current law to make a positive difference for tāngata whaiora as well as whānau and family. Most strikingly, participants were clear about what must change in the new law if we are to realise better outcomes from a system that aspires to place tāngata whaiora and whānau at the centre, grounded in Te Tiriti o Waitangi.

Ngā mea me whakarerekē | What needs to change

It is widely accepted that we should and must do better to meet the Crown's commitments under Te Tiriti o Waitangi and our international human rights obligations. Evidence supports the Government's direction in mental health to replace substitute decision making with supported decision making as best practice. Manatū Hauora has set out this direction in its revised guidelines to the Mental Health Act and its consultation document on transforming mental health law (Ministry of Health, 2021, 2022a).

In this report we have analysed statistics, relevant research, and voices of those most directly affected by CCTOs in practice. We want practice to be as consistent as possible with our international human rights obligations. Clinical reviews and court hearings are opportunities for tāngata whaiora to make decisions for themselves with support if needed, rather than have decisions made for them.

Voices in this report raise questions about the extent to which whānau and tāngata whaiora are involved and participate meaningfully in clinical reviews and court hearings. Such questions show there is more work to do to improve practices, even though currently responsible clinicians and judges must carefully consider the requirements of the legislation and align applications and decisions with established criteria. The clinical review and court hearing events are important mechanisms that exist to protect the rights of people subject to compulsory treatment, yet courts grant a remarkably high percentage of applications from responsible clinicians. If courts continue to grant applications for extension at the same rate (almost 90 per cent), the legislative change to eliminate 'indefinite' compulsory treatment orders will have minimal impact on the recognition of these rights.

The Government has made some steps towards repealing and replacing the Mental Health Act. However, it will take many years to replace the current mental health legislation and implement the new law fully. In the meantime, we want to see cultural and practice changes to protect and enhance mana (Huriwai and Baker, 2016) and uphold tāngata whaiora human rights—such as the right to be heard in decisions that could lead to compulsory community treatment.

Replacing the law

The new law and its implementation must uphold obligations under Te Tiriti o Waitangi and international human rights law.

Use of CCTOs enables substitute decision making and perpetuates inequity, particularly for tāngata whaiora Māori and Pacific peoples. CCTO use cannot

compensate for shortcomings in services, such as failing to provide adequate cultural and holistic approaches as treatment options.²¹ Offering a greater range of options will support and enhance tāngata whaiora safety and wellbeing in the community more effectively than CCTOs.

We anticipate the Law Commission's current review of the law on adult decision-making capacity will lead to important discussion on options and recommendations for change required to establish supported decision making in Aotearoa laws, including by replacing the Mental Health Act (Te Aka Matua o te Ture | Law Commission, 2022). Researchers have already begun exploring the interventions that can practically facilitate supported decision making (Gordon et al, 2022).

Adequately resourcing implementation of the new law will require leadership to continue to focus on prioritising initiatives and interventions that enable supported decision making in practice, including by expanding the cultural and peer workforce. The sustained effort required to achieve this transformation cannot be overestimated. Moving forward together, stakeholders will need to foster greater engagement and collaboration, based on deeper understandings of different perspectives. At the core of the change we are seeking must be the views and aspirations of tāngata whaiora.

Current practice must change to be more consistent with human rights

Currently, the Mental Health Act prevents Aotearoa from fully complying with human rights because of its definition of 'mental disorder' combined with its requirements for a legal procedure that privileges health professional and legal professional roles. We acknowledge that clinicians and legal practitioners are also constrained in practice by this complex process that perpetuates use of CCTOs.

While the Mental Health Act remains in force, an approach that respects human rights more consistently can and should be applied operationally within those constraints. The Mental Health Act contains provisions that enable services to improve their culture and practice to be more inclusive of tāngata whaiora and whānau. In its updated guideline, Manatū Hauora is noticeably clear that these changes in practice (and advance directives) are consistent with the current legislation and that services should apply them when enacting the Mental Health Act (Ministry of Health, 2022a). Manatū Hauora advises that it expect services to follow these updated best practice guidelines and their companion document, given they were put into effect under section 130 of the Mental Health Act and as such have the status of secondary legislation. We might have expected to see a reduction in CCTO use following the implementation of the updated guidelines given the guidance on

²¹ For example, an Australian study of stakeholder perspectives on how the operation of the mental health system affects the use of involuntary CTOs identified two key themes: CCTOs are used to access services and CCTOs cannot remedy non-existent or inadequate services (Light et al, 2017).

supported decision making, rights, and Te Tiriti o Waitangi, but this has not eventuated.

Collaborative and/or shared decision making does not always mean tāngata whaiora are making decisions for themselves. Mental health services need to move from exclusive to inclusive practices. Among those inclusive practices are sharing (clinical) information in plain language, taking more time for decision making, involving whānau, family, and other supporters in planning with tāngata whaiora, and supporting tikanga in court hearings. Whānau, family, and supporters should be practically involved in processes where tāngata whaiora need support to make decisions for themselves.

In relation to the court hearings, we acknowledge the vision for the District Court, Te Ao Mārama, that means ‘all people who come to court to seek justice will be seen, heard, understood and able to meaningfully participate’ (Ministry of Justice, nd). This judicially led kaupapa draws on best practice from specialist and therapeutic courts, such as the Alcohol and Other Drug Treatment Court. We suggest considering and adapting the approaches in Te Ao Mārama—which include solution-focused judging, using plain language, revised courtroom layouts, and tikanga Māori—for civil hearings under the Mental Health Act.

Together with the courts, services need to identify challenges to implementing cultural and practice improvements in the operations of the Mental Health Act, within their districts. For this purpose, it is vital to understand more about how clinical review and court processes can work to include multiple perspectives and privilege the perspectives of tāngata whaiora.

What needs to change?

Replacing the law

- We want to see the new mental health law based on supported decision making, and embedding Te Tiriti o Waitangi and a Te Ao Māori worldview.

Practices that need to change now under the current Mental Health Act 1992

- We want to see a reduction in the number of applications made and outcomes granted for CCTOs, and in the rate of CCTO use.
- We want to see a reduction in the inequitable use of CCTOs for Māori and Pacific peoples.
- We want to see services and courts implementing cultural and other practices that ensure their processes hear the perspectives of tāngata whaiora as well as of whānau and family, and tāngata whaiora lead in their decision making.

Concluding remarks

This report intentionally brings forward the experiences and perspectives of tāngata whaiora Māori, people with lived experience, family, and whānau related to the CCTO process. These human experiences help us to understand the impact of this legal process on people's lives and its counterproductive impact on the therapeutic relationship. Forced treatment can also reduce people's trust in and engagement with services. In the face of evidence that CCTOs are not effective, and the disempowering nature of this clinical and legal process, we need to work together to reduce this practice.

We acknowledge that health professionals, district inspectors, lawyers, and judges can bring important knowledge and understanding about these processes in practice. All of these perspectives will be critical to achieving the transformation that is needed. While our priority in this report has been to amplify voices of lived experience, we are committed to working with all stakeholders to help forge a different pathway that honours Te Tiriti o Waitangi and respects the rights of tāngata whaiora Māori and other people with lived experience. That pathway will be built on approaches that are effective in improving experience of services and most importantly in improving outcomes for all people in Aotearoa.

This report is part of the public conversation on reframing risk as recommended in He Ara Oranga. We consider that the reframing is about a shift from a focus on risk to a focus on the rights of tangata whenua and all people in Aotearoa who experience mental distress. We will continue to be a part of this important conversation.

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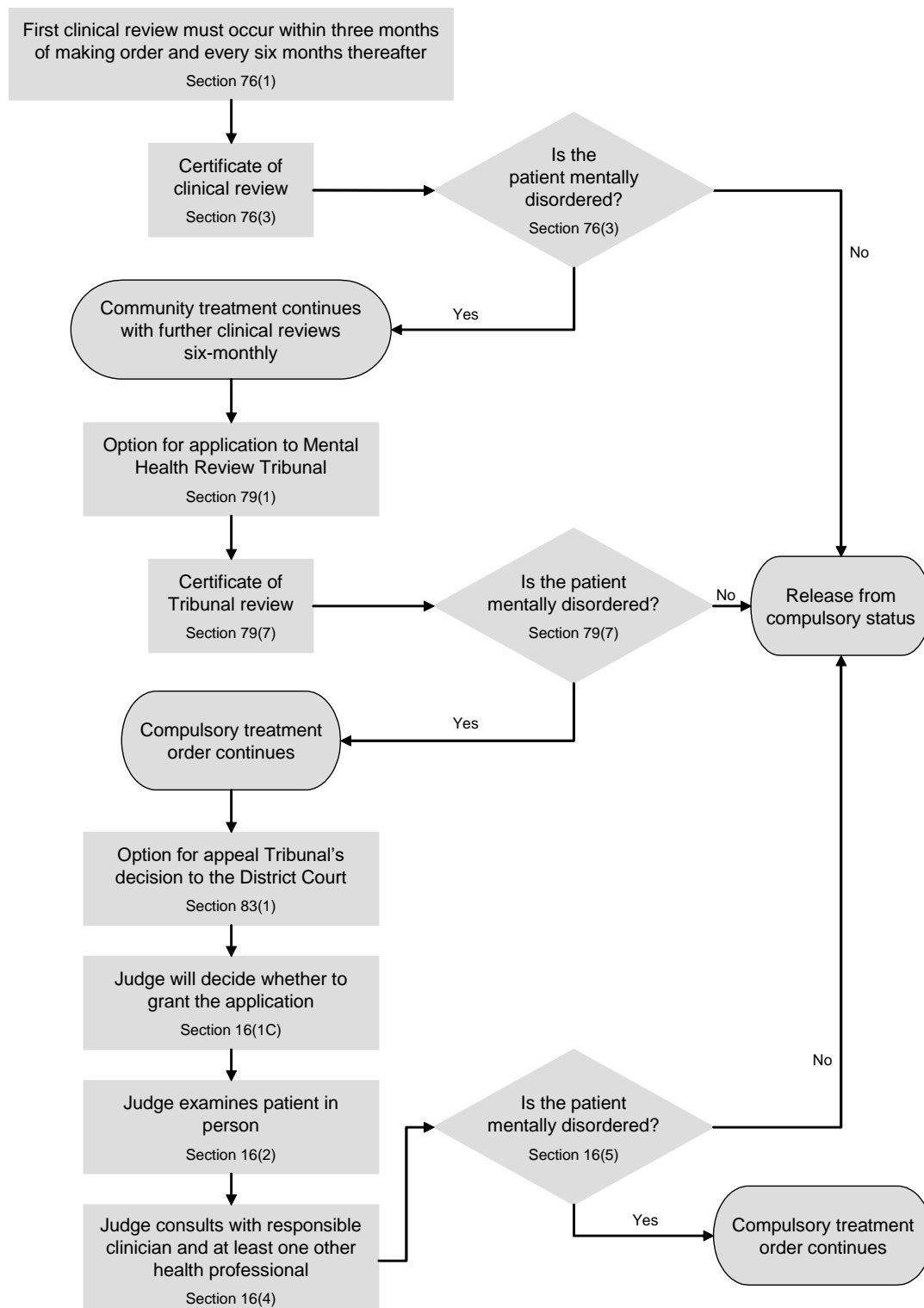
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Āpitianga tuatahi: Te tikanga hei arotake i ngā maimoatanga ā-hapori whakature | Appendix one: The process of reviewing CCTOs

Figure 1: Clinical and judicial review of patients under compulsory treatment orders (Ministry of Health, 2022a)



Āpitianga tuarua: Te tau tāngata kei raro i ngā maimoatanga ā-hapori whakature ā rohe | Appendix two: Average number of people under CCTOs by district

Average number of people on a given day subject to section 29 (CCTO) of the Mental Health Act per 100,000 population, by DHB, 1 July 2020 to 30 June 2021

Bay of Plenty	48	Waitematā	84
Lakes	65	Taranaki	90
Southern	67	National average	90
Canterbury	71		
Tairāwhiti	72	Auckland	100
Nelson Marlborough	74	MidCentral	107
Counties Manukau	75	Waikato	130
Wairarapa	78	Whanganui	136
Hutt Valley	80	Capital & Coast	167
West Coast	80	Northland	174
South Canterbury	82	Hawke's Bay	181

Source: Ministry of Health (2022c), Table 2, page 5.

Āpitianga tuatoru: Ngā āhuatanga hoahoa o te hinonga hei tāera i te raraunga kounga | Appendix three: Project design and methods for qualitative analysis

We sought the perspectives of people with lived experience, including Māori, tāngata whaiora, whānau, and family, to hear their views on the CCTO process and what changes need to happen to maximise tāngata whaiora autonomy and uphold rights. To do this, we held focus groups.

Recruiting people to focus groups

We sent emails to everyone in our lived experience database,²² inviting them to participate in a focus group to share their views on CCTOs. The email contained information about the scope of the focus group and who we were particularly interested in hearing from, including people who have had personal experience related to CCTOs, whānau and family of people with personal experience of CCTOs, and lived experience advisors and peer advocates with experience of the current process and practices related to use of CCTOs.

Where people were interested in participating, we asked them to choose from a lived experience focus group, a whānau and family focus group, and a Māori focus group that Māori staff would facilitate. We asked people to forward the invitation on to their networks so that we could reach people we had not connected with before.

Collecting the voices of tāngata whaiora, family, and whānau

Focus groups

We held three focus groups via Microsoft Teams, which consisted of:

1. one lived experience focus group attended by six people, including those who had experience of being under a CCTO
2. one whānau and family focus group consisted of eight people, including three Māori and some people who had loved ones with an experience of a CCTO
3. one Māori focus group for tāngata whaiora and whānau attended by five people. Some people who attended this focus group had loved ones with experiences of CCTOs.

²² The lived experience database consists of 250 people who have lived experience of distress, alcohol or other drug harm, gambling harm, or addiction. Some people in this database also work within the mental health and addiction sector in various roles, including within the consumer, peer support, and lived experience workforce across the motu.

Two people, one of whom was a lived experience advisor, facilitated each focus group.

Online form

We sent a link to an online form to people who couldn't attend a focus group, but still wanted to share their thoughts with us, as well as people who had registered for a focus group but were unable to attend. For consistency, the questions in the online form were the same as those asked during the focus group. In total, we received five online form submissions, three of whom were from Māori. Some respondents to the online form identified themselves as having experience of CCTOs or knowing people who had.

Focus group questions

Table 1 sets out the eight questions we asked the focus groups.

Table 1: Questions for CCTO focus groups

Applications for CCTOs
1. What are your reflections on the current processes for involving the person, their family and whānau, in planning and decisions?
Places for CCTO hearings
2. What are your views on the importance of physical spaces / locations for these kinds of 'hearing' discussions?
People and process involved in CCTO hearings
3. What are your views about who attends hearings under the Mental Health Act and how they are involved?
Getting taken off CCTOs by a responsible clinician, judge, Tribunal
4. How can people be supported in their choices and decisions?
Imagining possibilities
5. What would a system where there is no community compulsory treatment be like?
6. How would it be different to what exists?
7. How does the system and process need to change to respond to tāngata whaiora- and Māori-led needs and aspirations?
8. 'Who' or 'what' is most likely to bring about that change?

How we made sense of what we heard

We took a teams-based approach to qualitative analysis of the focus group material. The team included people with Te Ao Māori perspectives, lived experience perspectives, and qualitative research experience.

We analysed data from the focus groups²³ and the online forms using a reflexive thematic analysis approach (Braun and Clarke, 2022). Reflexive thematic analysis offered flexible guidelines, rather than a set of rules, to follow and provided us with a rigorous approach to narrow down what participants shared in the focus groups into key themes illustrated in this report.

To make sense of our data, we individually familiarised ourselves with the focus group discussions by watching and listening to the recordings before coding²⁴ extracts in transcripts relevant to the report's scope. In multiple team sessions, we combined our coded data and then sorted these into groups by searching for patterns of meaning. Together, we also generated initial themes that were common to the three focus groups and these themes were refined in our report writing process.

²³ By 'data', we are referring to the recordings of each focus group and their associated transcripts. Each focus group was recorded with the consent of every participant.

²⁴ By 'codes', we are referring to labels consisting of a couple of words or short phrases that described what a particular passage or sentence was about.

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