

19 December 2024

Submission on the Mental Health Bill

To the Health Committee,

Te Hiringa Mahara – the Mental Health and Wellbeing Commission (the Commission), welcomes the opportunity to make a written submission on the Mental Health Bill.

Summary of our key points

This Bill is a step in the right direction to update the Mental Health (Compulsory Assessment and Treatment) Act 1992. To embed a fully modern human rights framework in our mental health and addiction system, more work is needed to promote supported decision-making in practice and reform other relevant legislation.

- We broadly support the direction of the Bill that introduces **assessment of people’s decision-making capacity** as part of new criteria for compulsory assessment and treatment of people.
- We support the provisions in the Bill for promoting people’s own decision-making through **advocacy and support roles**, arrangements for **hui whaiora (well-being) meetings**, and an ability for people to make their own **statements about future care**.
- However, there are key areas to be strengthened. We recommend:
 - **seclusion** is eliminated within a specified timeframe under the Act
 - **courts** and **tribunals** decision-making procedures under the Act reflect best practice approaches aligned with the District Court’s Te Ao Mārama – Enhancing Justice for All
 - **community compulsory treatment/care** orders are reduced and eventually phased out
 - increased reporting on how the Act is implemented.

Achieving the intent of the Bill is dependent on workforce, investment, technology, and communication. People need clear pathways to access the care and support they need to continue their recovery and sustain their wellbeing in the community. Increased access to high-quality and people-centred services is critical, as are changes to clinical and provider practice. Addressing discrimination and stigma

across the system and in our communities will play a crucial role in ensuring the intent of this Bill is realised.

The Commission would appreciate the opportunity to make an oral submission and share these views with the Committee in person.

Our interest in the Mental Health Bill

1. The Commission was established as an independent Crown entity following **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction**. Our role under the Mental Health and Wellbeing Commission Act (2020) includes:
 - monitoring mental health and addiction services and advocating improvements to those services.
 - promoting alignment, collaboration, and communication between entities involved in mental health and wellbeing.
 - advocating for the collective interests of people who experience mental distress or addiction (or both), and the persons (including family and whānau) who support them.
2. Our role gives us a unique mandate and we choose to enact our advocacy function alongside, as well as on behalf of, lived experience communities wherever we can.
3. We believe that people who experience mental distress and people who experience substance harm, gambling harm or addiction must be involved at every level of the mental health and addiction system in genuine partnership. In our role we are committed to:
 - effectively seeking the views of people who have experienced mental distress or addiction (or both) and those who support them.
 - upholding Te Tiriti o Waitangi in all our work.
4. We have specific obligations in our Act to have regard to the experiences of Māori, and people who share a common identity, experience, or stage in life that increases the risk that they will experience poor mental health and wellbeing (such as people in groups identified by **He Ara Oranga** and listed in Schedule 2 of our Act).
5. Our role and responsibilities underpin our submission on the Mental Health Bill, which we broadly support.
6. In this submission, we outline our position on the broad policy context before commenting on specific recommendations for strengthening key elements in the Bill.

Our independent oversight of the mental health and addiction system

7. **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction** recommendation to repeal and replace the Mental Health Act 1992, offered a rare opportunity to transform the mental health and addiction system for people who experience mental distress or addiction (or both), and the persons (including family and whānau) who support them. Legislation is a key enabler for a mental health and addiction system that: is responsive and accessible and provides genuine choice of services and supports; embraces holistic and cultural worldviews of wellbeing; and understands safety from tāngata whaiora and whānau perspectives.
8. Our contribution to the Ministry of Health's public consultation document **Transforming our Mental Health Law** (2021) on repeal and replacement of the Mental Health Act, is summed up as follows (Te Hiringa Mahara, 2022). New legislation must protect the rights of tāngata whaiora on an equal basis with other people:
 - decisions made by tāngata whaiora should be upheld
 - tāngata whaiora should be supported to make their own decisions
 - decisions should only be made for tāngata whaiora as a last resort
 - protections are needed where tāngata whaiora cannot make decisions
 - solitary confinement (seclusion) must end
 - restrictive practices must be minimised with a view to elimination
 - protections are needed for assessment, treatment, review, monitoring and oversight.
9. The policy problems that the Bill is intended to address are well known. In Aotearoa New Zealand and other countries with similar mental health systems, many agencies, researchers, and commentators report on the complex and ethically contentious issues related to mental health services' use of coercive practices that are inconsistent with human rights and therapeutic care (Ministry of Health, 2022).
10. We have reported on Aotearoa New Zealand's high and increasing use of compulsory treatment under the Act, including an infographic on reducing coercive practices (Te Hiringa Mahara, 2024c). The current Act is inconsistent with a human rights-based approach and a philosophy of mental health recovery and wellbeing. Over the past five years, the number of people subject to compulsory community treatment orders has steadily increased from 128 to 135 people per 100,000 population. While the overall the number and proportion of people in

inpatient units subject to seclusion decreased over the last four years up to 2022/23. Ethnicity figures show there is persistent inequity, with higher use of seclusion and compulsory community treatment particularly for Māori and for Pacific people. While the number of people subject to compulsory community treatment is increasing overall, the number of Māori subject to these orders is increasing at a faster rate – by 13.0 percent from 2018 to 2020/21 compared with 5.8 percent for non-Māori, non-Pacific peoples (Te Hiringa Mahara, 2023b; Te Hiringa Mahara 2023c).

11. Over the past 20 years, there has been a global shift in mental health law, policy, and practice that aims to reduce and eventually eliminate use of coercion in mental health services. Modern human rights frameworks, such as the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), challenge the legitimacy of treating people unequally based on their psycho-social disability (mental illness). Research evidence challenges the lack of therapeutic effectiveness or social benefits from ongoing use of seclusion in hospital settings and compulsory treatment orders in the community. There is growing evidence on ways to avoid, minimise and eventually eliminate use of mandated coercive practices (Whittington et al., 2023).
12. In our view, this Bill is a step in the right direction to update our Mental Health Act 1992. More work is needed to fully embed a modern human rights framework for supported decision-making that complies with international treaty obligations. For the mental health and addiction system, we expect this work to include reviews of other relevant legislation, such as the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.
13. We acknowledge and broadly support the first half of the Bill that includes updated rights and introduces new roles and arrangements towards a modern supported decision-making legislative framework for specialist mental health care. Regarding policy objectives, we welcome clause 3 on the Bill's express purposes, clause 6 on principles underpinning use of compulsory care, and recognition of Te Tiriti in clause 5. We see these important changes will partially address policy problems of sustained and inequitable use of the Act.
14. However, we believe that the Bill does not go far enough to enable the shifts in practice we want to see lead to better outcomes for people. The Bill's second half retains substituted decision-making roles and processes that are largely unchanged from the current Act (such as a responsible practitioner and a court hearing as the model for applications and orders for compulsory care, discussed in paragraphs 44 and 45). The Bill should be strengthened to make the most of the rare opportunity to enact meaningful change needed to achieve the policy objectives.

15. In the context of broader law reform, we consider a more UNCRPD consistent approach would be to have legislation that promotes supported decision-making, in relation to a person with affected decision-making capacity, regardless of cause. We acknowledge the Law Commission's work to review and reform adult decision-making capacity law (Te Aka Matua o te Ture | Law Commission, 2024). We suggest the Committee consider regulating civil commitment and criminal justice procedures as separate pathways. (See discussion under headings '[compulsory care and assessment](#)' and '[people in the justice system](#)' in this submission).
16. In the Bill's current form, the implementation of the objective to promote supported decision-making could be frustrated with the mix of new advocacy and support roles operating alongside existing statutory roles under the Act. With the current model for applications and decisions on compulsory care orders remaining intact, it is not clear how new authorised roles (such as nominated persons) will effectively exercise their authority alongside responsible practitioners. A reformed approach that enacts collaborative decision-making authority and responsibility under the Act will support practice shift and lead to outcomes that respect people's rights, will and preferences, to make decisions about their care.
17. Achieving the intent of the Bill is dependent on Government action on other enablers of workforce, investment, technology, and communication. We have reported on workforce challenges in the sector, such as shortages and resource constraints, and the impact on people's decreasing access to specialist services (Te Hiringa Mahara, 2024b, p60). This year we also published an insights paper on the need for increasing availability and access to acute options for mental health care other than hospital-based care and treatment (Te Hiringa Mahara, 2024a).
18. The system is under pressure. Investment in more - and a broader range of - services is needed to respond to people in crisis. Once the 'crisis' moment in time is passed, people need clear pathways to access care and support they need to continue their recovery. These pathways must include community-based, peer-led, Kaupapa Māori services and social support for securing safe housing, engaging people in meaningful activities, and obtaining employment. These kinds of services have significant benefits for people's wellbeing and are critical in order to reduce, even avoid, the use of compulsory treatment.
19. In the context of these policy and implementation considerations, we set out below our comments on key areas of focus for our submission on the Bill itself. Our comments with specific recommendations are grouped under similar headings used in the Bill's explanatory note that describe key areas of change.

Our position on key policy areas and specific recommendations

20. We recommend changes to the Bill to enable practice that respects people's rights to make decisions about their care and treatment and supports their capacity to do so.

Purpose and principles

21. Priorities of people with lived experience of the Mental Health Act are for the Bill to respect and strengthen individual autonomy in decision-making capacity about their own care and wellbeing, uphold Tino rangatiratanga and, adopt a holistic approach to wellbeing which respects Te Tiriti and diverse worldviews (Te Hiringa Mahara, 2022; 2023c).

22. We support embedding the purpose to reduce inequity if we are to reduce persistent inequitable rates of coercion for Māori in particular and for Pacific people who are overrepresented in Mental Health Act data.

23. We recommend that international treaties are expressly referred to in the Bill, including in standards and guidelines issued under the Act, such as: United Nations Convention on the Rights of Persons with Disabilities, United Nations Declaration on the Rights of Indigenous Peoples, United Nations Convention on the Rights of the Child, United Nations Optional Protocol to the Convention Against Torture. These obligations underpin the Bill's purposes and principles.

24. We support the Bill's introduction of clear principles to guide decisions about compulsory care that:

- serve a therapeutic purpose
- are applied in a least restrictive way
- are supportive, responsive and encourage a person to develop and exercise capacity and choice, reflect needs, will and preferences of a person, and recognise ties of family, whānau, hapū, iwi, and family group.

25. To give effect to Te Tiriti o Waitangi principles in the Bill, beyond the list of provisions in clause 5(a)-(g), the ways in which principles are intended to be operationalised could be reflected throughout procedures in the Bill. By this we mean the arrangements for rōpū whaiora (collaborative care team) and hui whaiora (well-being meetings) should specify culturally appropriate forums and meeting places. Procedures need to also consider the role of hapū and iwi.

26. For the purposes of implementation, we recommend the co-design of procedures referred to in the Bill to mitigate practices that are likely to perpetuate persistent inequity of outcomes, especially for Māori.

27. We support Te Tiriti principles and rights-based approaches being consistently adopted in review and reform of legislation relevant to people's mental health and wellbeing. Coherence of purpose and principles will aid interpretation and application of the Bill and other legislative reform underway to embed a modern rights-based approach in provision of mental health and addiction services.

Supported decision making, including family and whānau involvement

28. We are pleased to see the requirement for reasonable assistance to support people to participate in decisions, understand processes, and express their views.

29. The new support and advocacy roles, including arrangements for family and whānau involvement, are a positive addition to the Bill. We want to see that these roles, for example, nominated persons, have authority in and across all decision-making procedures under the Bill, such as in hui "rōpū whaiora" (collaborative care team). A key issue to highlight is how the authority of these new roles will increase the ability to influence and support decisions about care. Responsible practitioners will convene hui at their discretion. Attendees can include the person, rōpū whānau, members' of the person's support network, and an independent advocate, for example. While this is an improvement in terms of representation and participation, it may not be sufficient to ensure people's will and preferences are respected if these are not consistent with clinicians' views.

30. We support the new provision for "hui whaiora" (well-being meetings) for care planning and decision making and for resolving issues in a manner that is restorative. Regarding arrangements for hui whaiora, through our engagement, we heard from whānau supporting people under the Mental Health Act that the Bill's provisions to strengthen their involvement in planning need to acknowledge people's parental obligations and needs of their tamariki and children.

31. We broadly support the introduction of "compulsory care directives" or statements about future care as a mechanism to promote supported decision-making in mental health care (clauses 12 to 15). The priorities for lived experience communities are to enable and uphold individual statements about future care, such as under the existing right to make an advance directive in right 7(5) of the Code of Rights, under the Health and Disability Commissioner Act 1994. There is an inconsistency in the Bill adopting a tool intended to enable and uphold a person's will and preferences which can then be overridden. We recommend that the Bill is clearer about how "compulsory care directives" will be upheld alongside other relevant law (such as Advance Directives in the Code of Rights and Statements of Intent in the updated Protection of Personal and Property Rights Act). We recommend guidelines on statements about future care are issued under the Act as an aid to communication and application. Guidance will need to support practical implementation, for example the arrangements for

administration and access to update statements in people's health records or in a national repository.

Rights and complaints

32. We support the updating of existing rights and extending them to people who are receiving 'voluntary' inpatient care.
33. We recommend the right to a peer support person where available be included in the Bill. Lived experience communities have told us that recognition of and access to peer support services in the Act is important to them (See also our [Peer Support Workforce insights paper](#), Te Hiringa Mahara, 2023a).
34. Rights and complaints processes, including information about how to access support under the Act, should be easy to understand and accessible for tāngata whaiora and whānau to follow. We expect this to include information being available as needed in te Reo Māori, Pacific and Asian languages, NZ Sign, and braille.
35. We recommend more clarity on the interaction of the new support and advocacy roles with the established role of District Inspector, for example the process to raise concerns and discuss issues and make complaints. This is particularly important given the District Inspector role of independent statutory monitoring and gatekeeper to access formal procedures for review and appeal of compulsory care orders.
36. We strongly support the Mental Health Review Tribunal and new Forensic Patient Mental Health Review Tribunal procedures including lived experience and cultural expertise, in addition to legal and clinical expertise.

Compulsory care criteria

37. We support the introduction of new entry and exit criteria for compulsory care and (or) treatment, so a narrower definition will not apply to people with decision-making capacity. Voluntary care options should always be actively offered. Access and availability of "options" in the "proposed patient's" own community or rohe depend on other enablers for successful implementation of the Act: workforce, investment, communication, and technology.
38. We broadly support compulsory care criteria for a person with seriously impaired mental health that causes (or is likely to cause in the near future), in the absence of care, serious adverse effects. We are pleased to see the criteria above are not intended to apply unless a person lacks capacity to make decisions about their own mental health care.
39. The new compulsory care criteria appear narrower because of the additional capacity criterion, but in practice will depend on who is involved and authorised to

make an assessment (such as non-clinical and cultural perspectives). The criteria also appear broader because “serious adverse effects” is expanded to include and specifies psychological harm to others.

40. The test for justification of continued compulsory care is new: a “sustained basis” for an individual’s decision-making capacity. We recommend the exit criteria for compulsory care is strengthened under the Bill. We want to see increased monitoring of care plans and compulsory status reviews under the Act.

Compulsory assessment and care

41. We support the introduction of a new “care plan” clause 43, where care plans are to include holistic assessment and cultural considerations in relation to non-pharmaceutical options of care. The Bill could include a clearer definition of “non-pharmaceutical” options and how far this embeds holistic practices, such as rongoa Māori. Again, processes for who assesses and ultimately decides the appropriateness of these options needs to be clear; the hui whaiora, hui rōpū (collaborative team), or responsible practitioner. As a minimum requirement for successful implementation, these template care plan documents need to be co-designed with people with lived experience and cultural expertise.
42. We advocate for reduced rate of compulsory orders overall and reduced inequitable use of these orders for Māori and Pacific people. We advocate for services and support that are culturally capable and have the ability, capacity, and capability to effectively engage with and support people early and through an acute episode. We recommend alternative options for support are developed and provided so that use of compulsory care and treatment for people living in the community can be reduced and eventually phased out.
43. In our 2023 focus report on [Lived Experiences of Community Compulsory Treatment Orders \(LECCTO\)](#) we commented that studies reinforce that these compulsory orders have limited, if any, clinical effectiveness, and that people’s experiences of compulsory community treatment are not therapeutic (Te Hiringa Mahara, 2023c).
44. The carrying over of the Family or District Court arrangements for initial decisions on mental health compulsory orders appears at odds with the policy objectives towards a rights-based recovery approach under the Bill. We recommend the Committee consider an application ‘hearing’ based on a tribunal decision-making model, instead of a court. Lived experience communities provided feedback that they can feel like their whānau have done something wrong and speak of the need for a new name for the ‘court’ process that is restorative and acknowledges trauma and pain that is more than ‘mental illness’. The current process is not typically experienced or conducted in an environment that is conducive to wellbeing (Te Hiringa Mahara, 2023c).

45. We are pleased to see the requirement for “patient participation in decision making” that extends to the Court and Tribunal procedures. In our LECCTO report we called for services and courts to implement practices that ensure perspectives are heard, and tāngata whaiora make decisions about their care. We want to see procedures strengthened to reflect Te Ao Mārama – Enhancing Justice for All best practice in District and Family Court settings (Te Hiringa Mahara, 2023c).
46. The current court hearing and decision-making process is conducted in private and accessible evidence is lacking to inform practice change that will be beneficial for people subject to these processes and those who participate in these hearings. We need in-depth understanding of local processes that sustain high and inequitable rates of compulsory treatment if we are to reduce and eliminate restrictive practices. This means rethinking how the participants’ roles, the places, and the documents, involved in these processes might be re-designed-for-support so services avoid use of compulsory orders under the Act (Schneller et al., 2024).

Reducing and eliminating use of restrictive practices

47. We support the policy intent to reduce and eliminate use of restrictive practices, including seclusion. There is a global movement towards ‘zero coercion’ in mental health services and this intent should be embedded in an updated Act (World Health Organisation, 2023; Herrman et al., 2022).
48. While we understand that there are resource requirements to enable seclusion to be eliminated (including workforce development and ensuring adequate physical environments), we do not consider these requirements prevent the inclusion of a ‘sunset’ clause that specifies an end date for the use of seclusion (See also [Ki te Whaiora Understanding Kaupapa Māori approaches to compulsory mental health care](#), Te Aka Whai Ora | Māori Health Authority, 2024.)
49. We recommend the Committee eliminates seclusion under the Bill via introduction of a ‘sunset clause’ that removes seclusion as a permitted practice within a specified period from the date of enactment.
50. We recommend the Bill be strengthened with additional requirements for a phased timeframe for elimination, alongside an implementation plan that is adequately resourced and monitored. To achieve this, more and a broader range of services must be available earlier in the course of a person’s distress. While the policy sets out an intent to end seclusion and other restrictive practices, without a mechanism for achieving that in the Bill itself, such as a sunset requirement, the aim of elimination simply will not be achieved. Some mental health services have been able to achieve reduced or zero use of seclusion through a sustained focus and commitment to monitoring, quality improvement activity, education, and training, such as that facilitated by the Health Quality and Safety Commission.

Children and young people

51. We are pleased to see the requirement in clause 38 for people aged under 18 to be cared for by child and adolescent mental health services. We advocate for reducing the number of young people (aged 12 to 17 years) admitted to adult inpatient mental health services to zero (Te Hiringa Mahara, 2023d, p28). The admission of young people into adult mental health inpatient services has decreased over the last decade, however, one in four young people who are admitted to inpatient care is admitted to an adult service – over 150 young people each year are still admitted to adult units.
52. We heard through feedback that admitting young people to adult services is causing harm and reducing their sense of hope. The negative impacts of this practice outweigh any potential positives, and young people and their whānau and family should not have to choose between age-appropriate services and services close to home. Young people want to be involved in co-designing youth-specific acute response services across Aotearoa. We have recently recommended Health NZ provide guidance for the delivery of effective acute community options tailored to meet the needs of rangatahi and youth (Te Hiringa Mahara, 2024b, p60). (See also thematic issues in report [Monitoring places of detention 2022/23 Annual report of activities under the Optional Protocol to the Convention against Torture \(OPCAT\)](#) published by Te Kāhui Tika Tangata | Human Rights Commission, 2024.)
53. In the Bill we welcome additional requirements and protections in clause 38 to ensure that people under the age of 18 are prohibited from being placed in seclusion and (or) given a restricted treatment. The prohibition on people under 18 being provided with electroconvulsive therapy is subject to an exception for when it is considered “reasonably necessary”. We recommend the Director of Mental Health to issue guidelines and (or) standards to regulate and monitor this practice and as an aid to communication in the operation of clause 50 on use of electroconvulsive therapy.

People in the justice system

54. We endorse extension of enhanced rights and support to forensic patients detained in hospital or transferred from prison under compulsory care. We support the introduction of a Forensic Patient Review Tribunal, modelled on the Mental Health Review Tribunal under the current Act. We also advocate that people have access to mental health and addiction care that supports their recovery, whether detained on remand and (or) in prison. (See also thematic issues in report [Monitoring places of detention 2022/23 Annual report of activities under the Optional Protocol to the Convention against Torture \(OPCAT\)](#) published by Te Kāhui Tika Tangata | Human Rights Commission, 2024.)

55. We believe civil commitment and criminal justice pathways under one Bill is a factor in ongoing stigma and discrimination, because it conflates criminal offending with mental illness and that perpetuates a harmful myth. For this reason, we support different arrangements and procedures being established under both criminal justice and civil commitment pathways that facilitate open dialogue between participants regarding safety and risk and how these discussions can be engaged in without bias or fear. **He Ara Oranga** recommended a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk. (See also Ministry of Health discussion document [He Arotake ngā Tūrarū Reviewing Risk](#), Changem Ltd, 2022).
56. We would like the Committee to consider whether the Bill ought to be separated into two Acts – one that applies to forensic patients under the criminal justice pathway and the other which applies to people under the civil commitment pathway. The Act for people under the civil commitment pathway potentially could be repealed once we have new capacity-based legislation in relation to a person with affected decision-making capacity regardless of cause; we suggest such an approach to embedding supported decision-making is more consistent with the UNCRPD.

Monitoring, oversight, and reporting roles

57. We recommend that the Bill goes further to strengthen system accountability and influence system change. Key statutory roles of Director of Mental Health, Directors of Area Mental Health Services, and District Inspectors are carried over from the current Act and their respective roles and functions remain largely unchanged.
58. We are pleased to see new provisions that require the Director of Mental Health to report annually on implementation of the Act (clause 211) and a five-year review of the Act (clause 212), and for the Minister to establish an advisory committee to advise on operation of the Act (clause 213). We recommend an additional requirement for consultation with the Mental Health and Wellbeing Commission on the review of the Act in clause 212.
59. We support the flexibility provided for ‘secondary legislation’ in clauses 202-205, such as the ability to prescribe by regulation improved methods for data collection. Current Mental Health Act statistics collection nationally is limited and delayed with manual adjustments required. The Office of the Director of Mental Health and Addiction Services’ regulatory report typically takes over 15 months to be published. We advocate for services reporting accurate data on use of the Mental Health Act that can be publicly reported within three months of the end of each financial year, including seclusion and compulsory treatment orders (Te Hiringa Mahara, 2023b).

60. We recommend the Bill require collection on the use of restrictive practices in mental health services including involuntary sedation and use of physical restraint. We have heard from lived experience communities about monitoring unintended consequences. For example, if use of one practice such as seclusion is reduced, then monitoring to check for any increased use in physical restraint or sedative use.

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