



Image from *Photovoice: This is how I see it*, OCC

Submission to the Ministry of Health

Child rights in mental health compulsory assessment and treatment

About the Office of the Children's Commissioner

Like most New Zealanders, we want every child to grow up knowing they belong, with a whānau who have what they need to live a good life.

The OCC represents 1.2 million people in Aotearoa New Zealand under the age of 18, who make up 23 per cent of the total population.

We advocate for their interests, ensure their rights are upheld, monitor places where children and young people are detained, amplify their voices and ideas, and help government agencies to listen and act on them.

This submission is focused on children and young people under age 18, to whom we refer as 'mokopuna'. We also touch on issues when tangata whai ora (a term we use for those with mental illnesses) under the Mental Health Act¹ have dependent children, and the role of the State legislation in respect of those mokopuna.

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¹ Mental Health (Compulsory Assessment and Treatment) Act 1992

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Recommendations

- 1) All legislation and policy should give effect to Te Tiriti, including explicit reference to it. This includes:
 - a) partnership with the Māori Health Authority
 - b) building Māori capacity to design and deliver mental health services
 - c) ensuring equity in resourcing to Māori mental health service providers.
- 2) The Māori Health Authority should have a key role in determining Māori approaches to compulsory orders
- 3) Uphold the rights of Mokopuna whai ora to be fully informed, have genuine treatment options, and give informed consent.
- 4) Treatments must meet cultural needs. This includes embedding holistic models of care such as Te Whare Tapa Wha.
- 5) Mokopuna whai ora should always be assumed to have capacity to consent, unless there is legitimate evidence otherwise.
- 6) The views of mokopuna must be taken into account, in accordance with their age and maturity, and they must be provided a safe and supportive environment in which the mokopuna can develop their views.
- 7) Except where the child's best interest requires otherwise, separation between adults and children in mental health facilities should be mandatory.
- 8) Environments where mokopuna are kept should be therapeutic, safe, and healthy. They must provide for the rights of mokopuna, including access to green spaces and outdoor sunlight, outdoor recreation, education and contact with whānau.
- 9) Seclusion of mokopuna should never be used or allowed.
- 10) Physical restraint should not be used except as a last resort and where necessary to prevent imminent harm to a person. The legislation must set a high bar, to minimise the use of physical restraint.
- 11) Guidelines should be established in consultation with affected communities to define, and guide when physical restraint may and may not be used, and methods.
- 12) Any use of physical restraint should be subject to mandatory reporting.
- 13) Voluntary whai ora must receive the same protections as those tangata whai ora under compulsory treatment.
- 14) Mokopuna and whānau must be provided with information and treatment options in a format that is consistent with their cultural, religious, linguistic, disability and ethnic needs.
- 15) Enable support for caregivers of mokopuna such as caregiving support, training, and advocacy.
- 16) Strengthen and uphold the independence of mental health system monitoring functions. Monitoring should include experiences of those subject to compulsory orders, and other aspects of treatment including transition plans.

- 17) Uphold existing, or enable new, complaints mechanisms that are accessible to mokopuna and their caregivers.
- 18) Legislation should provide for a system that is both non-discriminatory, and allows for bespoke treatment plans for mokopuna to take into account exacerbating factors when managing waitlists, to ensure access for those with greatest need.
- 19) Compulsory interventions (that may be applied without consent) must only be used as a last resort, defined using a high threshold.
- 20) Any compulsory treatment should be for the shortest possible duration.
- 21) The reforms should disallow indefinite treatment orders.
- 22) There should be an independent monitoring function to ensure greater oversight over treatment decisions, processes, services (as experienced by tangata whai ora), and effectiveness of transition plans.

Submission from the Office of the Children's Commissioner

"The Mental Health Act should be repealed and replaced. Any new law needs to reflect a human rights-based approach, align with modern models for mental health care and minimise the use of compulsion, seclusion and restraint." (*He Ara Oranga, page 191*)

Reforms should consider impacts on children and young people

Getting it right for children and young people under age 18 - referred to herein as *mokopuna*² - will ensure a mental health system that works well for everyone. We recommend the Ministry of Health undertakes a child impact assessment³ while developing this legislation, to ensure its provisions uphold the rights of children as articulated in the UN Convention on the Rights of the Child (Children's Convention).

New Zealand is a signatory to the Children's Convention. This means the government is obligated to incorporate *mokopuna* rights, as articulated in the Children's Convention, into legislation, policies, and practices. Upholding the rights of *mokopuna* requires ensuring *mokopuna* with mental illness can access mental health treatments that work well and support them to live fulfilled lives.

If the mental health system and its services work well for *mokopuna*, there are increased benefits for other population groups also.

Reforms should uphold and apply Te Tiriti o Waitangi

Te Tiriti o Waitangi (Te Tiriti) is the founding rights document and the template for partnership and unity for Aotearoa, New Zealand. All legislation and policy should give effect to Te Tiriti, including explicit reference to it. This includes adhering to the rights of power sharing and authentic relationships.

² Drawing from the wisdom of Te Ao Māori, we have adopted the term *mokopuna* to describe all children and young people for whom we advocate, aged under 18 years of age in Aotearoa New Zealand. This acknowledges the special status held by *mokopuna* in their families, whānau, hapū and iwi and reflects that in all we do. Referring to the people we advocate for as *mokopuna* draws them closer to us and reminds us that who they are, and where they come from matters for their identity, belonging and wellbeing, at every stage of their lives.

³ <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/resources/child-impact-assessment.html>

The Ministry of Health should be required to partner with the Māori Health Authority authentically and substantively, on how to give effect to te Tiriti in the legislative replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992. There are opportunities in this legislation to implement recommendations⁴ of the Waitangi Tribunal's Health Services and Outcomes Inquiry (Wai 2575).

In order for the Act's replacement to meet te Tiriti obligations; work with Māori across the design and implementation of the legislation is needed. This requires Māori-led definitions and designs for how tino rangatiranga, equity, and by-Māori for-Māori services are applied.

Equity issues for mokopuna accessing mental health services, including residential services, are illuminated by the fact that 44% of mokopuna whai ora in mental health units are Māori⁵, compared with 60-70% of mokopuna in care and protection or youth justice residences being Māori. This raises a question about the accessibility of mental health services to Māori versus other ethnic groups.

How Te Tiriti is given effect, depends on building Māori capacity to design and deliver mental health services, as well as ensuring equity in resourcing to Māori mental health service providers. The Māori Health Authority should have a key role in determining Māori approaches to compulsory orders (or temporary compulsory interventions within consented treatment plans).

Te Whare Tapa Whā

There is already an agreed model of holistic health service provision in Aotearoa New Zealand modelled on 'te Whare Tapa Whā.' This model provides for four different aspects of wellbeing: taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health).

These should be embedded in, or enabled by, new legislation.

Kaupapa Māori services

There is a large need for more kaupapa Māori services for Māori across the mental health system. We understand that there have been targets set and that work is being carried out to support more kaupapa Māori services to provide mental health services. Having strong provisions in legislation to give effect to Te Tiriti o Waitangi, including partnership with the Māori Health Authority, could be a driver to better support kaupapa Māori services.

⁴ <https://waitangitribunal.govt.nz/assets/Documents/Publications/Hauora-Chapt10W.pdf>

⁵ Page 52 of [Discussion Document](#) "In 2020, there were 433 children and young people aged 17 years or younger under the current Mental Health Act. Of these, 191 were Māori (44 percent)."

Reforms should progress implementation of the Children’s Convention and other rights instruments

The new legislation should uphold mokopuna rights as articulated in the Children’s Convention, the UN Convention on the Rights of Persons with Disabilities (UNCRPD), the UN Convention on the Rights of Indigenous Peoples (UNDRIP), the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), and other relevant UN conventions including the Convention on the Elimination of All Forms of Racial Discrimination (CERD) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

In terms of the rights of mokopuna, examples include treatment spaces for children and young people that are separate to adults, access to information, and participation in decision-making.

Legislation needs to uphold principles and articles of all relevant international conventions and human rights instruments. Undertaking a Child Impact Analysis can be a useful way to analyse how proposed changes to legislation will impact children’s rights.

Services must be rights-respecting

In recognising the rights of mokopuna, legislative reforms should require that policy and practice adheres to, and progresses, the implementation of the Children’s Convention. This includes the rights of mokopuna to whānau relationships, access to services that are responsive to their cultural, ethnic, religious and linguistic needs, and that they are non-discriminating. Specifically, mokopuna Māori have rights as mana tamariki and descendants of Te Tiriti o Waitangi, to grow and prosper as Māori.⁶

Compulsory Assessment and Treatment is, in a way, a process of overriding rights. In recognising the importance of respecting mokopuna in these circumstances, legislation needs to ensure mokopuna can participate in decision-making, and are protected from harm. Services should be delivered in partnership with mokopuna with reasonable inclusion of their caregivers, guardians, whānau, parents or other people the mokopuna identify as being their trusted support people.

Participation and informed consent

Participation in treatment decision-making means obtaining continual consent for assessment and treatment in accordance with the capacity and cognition of

⁶ <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html> and <https://www.occ.org.nz/publications/reports/te-kuku-o-te-manawa/>

mokopuna. The Health and Disability Code of Rights sets the standards for all health treatments to be provided, including rights to be fully informed, having genuine treatment options, and giving informed consent.

Mental health services for mokopuna should ideally be responsive early on in their illness, so that compulsory interventions (that may be applied without consent) are only used as a last resort and only when mokopuna do not have capacity to consent at the time.

While we understand that compulsory treatment is sometimes required as an immediate intervention in the best interest of mokopuna, we also believe that ongoing treatment of tangata whai ora must be subject to continuous consent.

Assumption of capacity to consent

Service providers should always assume mokopuna have capacity to consent (as a starting point) and always ensure they can participate in their treatment decisions as soon as they are able to. Mokopuna can be given information and options when they are in a stable condition, and be included in decision making, reflecting their capacity to understand the consequences and provide informed consent.

Parents, whānau and others must consider views of mokopuna

Parents and others legally responsible for mokopuna have an obligation to take into account the views of mokopuna, in accordance with their age and maturity, and to provide a safe and supportive environment in which the mokopuna can develop their views. The Committee on the Rights of the Child have clarified that: *"Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with Article 12 of the Children's Convention. However, if the mokopuna is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the 'best interest of the child' (Art 3)." (paragraph 32).*⁷

Protecting and fulfilling the rights of mokopuna

Ensuring mokopuna are cared for in settings specifically for children and youth

Except where the child's best interest requires otherwise, separation between adults and children in mental health facilities is consistent with the Children's Convention requirement that *"where children are deprived of their liberty, ...they shall be separated from adults ... and shall have the right to maintain contact with their family"* - Article 37(c)⁸.

⁷ [Children's Convention General Comment 4 \(2003\)](#)

⁸ "Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's

Mokopuna under 18 should only be in child and youth-centric secure treatment facilities. Having child and youth-specific units gives an opportunity to provide safer environments specific to the needs of mokopuna. If mokopuna are transitioning to adult services, there needs to be a focus on continuity of care.

Mokopuna should be treated by specified experts

Mokopuna require some additional protections (as contained in Part 8 of the current MHA). Throughout the care of mokopuna under any compulsory treatment, a psychiatrist practising in the field of child psychiatry must, wherever practicable, conduct the assessment and take part in the review of the condition of the mokopuna.

For mokopuna Māori, compulsory orders and psychiatric intervention should be conducted by professionals that are able to demonstrate to the satisfaction of the Māori Health Authority knowledge of tikanga and expertise in working with Māori. This needs to be supported in new legislation and strengthened to ensure child psychiatry expertise is always used unless it would serve no benefit to the child.

End the use of seclusion and minimise the use of restraint

The seclusion of children and young people, by its very nature, runs contrary to international human rights law which completely prohibits its use with children under 18 years of age.^{9 10} *"In accordance with views of the Committee against Torture, the Subcommittee on Prevention of Torture and the Committee on the Rights of the Child, the Special Rapporteur is of the view that the imposition of solitary confinement, of any duration, on children constitutes cruel, inhuman or degrading treatment or punishment or even torture."* Seclusion of mokopuna should never be used or allowed. Seclusion should be abolished and not used for disciplinary measures. There are far better ways to safeguard mokopuna and staff without the use of seclusion.

Physical restraint should not be used except as a last resort and where necessary to prevent imminent harm to a person. It is important to reduce, and aim to eliminate, the use of these practices.¹¹ The new legislation must set a high bar to minimise both use and length and ultimately eliminate seclusion or physical restraint, particularly for mokopuna. This would be consistent with the recent New Zealand Standard: Ngā paerewa, health and disability services standard.¹²

best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances." Children's Convention Article 37(c).

⁹ Children and Youth Report of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment, Human Rights Council, U.N. Doc. A/ HRC/28/68 (5 March 2015) (Juan Mendez).

¹⁰ Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc. A/66/268 (5 August 2011) (Juan Mendez)

¹¹ [Time for a Paradigm Shift Print.pdf \(hrc.co.nz\);
https://www.hrc.co.nz/files/9216/0749/3332/Time for a Paradigm Shift Print.pdf](https://www.hrc.co.nz/files/9216/0749/3332/Time%20for%20a%20Paradigm%20Shift%20Print.pdf)

¹² NZS 8134:2021 :: Standards New Zealand; <https://www.standards.govt.nz/shop/nzs-81342021/>

Guidelines should be produced and used to minimise the use of physical restraint – defined as physically holding or moving a child against their wishes. Any use of physical restraint should be subject to mandatory reporting.

The guidelines can be required by legislation, and established in consultation with affected communities (eg mokopuna, disabled people, Māori, and Pasifika peoples). Accurate data on the use of seclusion and restraint must be collated and reported, aggregated by age, gender, and ethnicity. Additional measures must be taken to address the disproportionate use of seclusion and restraint on Māori and Pasifika tangata whai ora.

Ensure mokopuna are cared for in therapeutic environments

Mokopuna are more likely to respond better in child-friendly therapeutic environments designed specifically for them. Examples include access to break-out rooms, spaces that are clean, calmly decorated, relaxing, and with natural light. These environments should fulfil children’s rights as articulated in the Children’s Convention, to receive the best healthcare possible including healthy environments (article 24), rights to recreation (article 31), contact with whānau (article 9), information and communication (article 13), and access to education (article 28).

Importantly, access to recreation for mokopuna means being able to go outside and enjoy fresh air, natural sunlight, and greenery, such as walking in a garden, playing ball, and other forms of outdoor exercise and recreation.

Equity of rights for all mokopuna whai ora

There are sometimes whai ora who choose (or are encouraged to volunteer) to be held in a secure unit for their mental health treatment. It is important that they receive the same protections as those tangata whai ora under compulsory treatment orders. For example, access to advocates currently provided through District Inspectors, should be available to voluntary whai ora. The requirement for ongoing consent, and genuine treatment options should be available to all people in secure facilities, both voluntary and those under compulsory orders.

Partnership with mokopuna and whānau

Mokopuna wellbeing is intrinsically linked to their whānau and relationships in their communities/hāpori and hāpu. The legislation must recognise the clear role of whānau in the treatment decisions, recovery, and wellbeing of mokopuna.

Mokopuna and whānau must be provided with all options in a format that is consistent with their cultural, religious, linguistic, disability and ethnic needs, so they are properly informed.

Relationships are so important for mental wellbeing, that the legislation should have special provisions that support things like collaboration among treatment providers

and those people identified by mokopuna as being core to their recovery, such as parents, caregivers, whānau and peers.

For example, the mental health system should also enable support for caregivers of mokopuna, such as provision of caregiving assistance, training and advocacy after discharge, to support them to ensure transition plans are implemented. Caregivers have called for training to help them support their mokopuna whai ora. In addition, we are aware transition plans are often not well implemented – and this is exacerbated for mokopuna who move from the care of one agency (eg a mental health unit) to another (eg Oranga Tamariki). Support for whānau should enable them to advocate for the needs of mokopuna, and ensure they have the resources needed to do so. Whānau may also need assistance to care for mokopuna in the community, and provision of such support should be enabled by legislation.

Independent monitoring is critical

Legislation should strengthen and uphold the independence of mental health system monitoring functions. Independent monitoring is critical to ensure the intent of legislation is delivered. Different aspects of monitoring functions are currently carried out by the Ombudsman, the Office of the Children’s Commissioner (under its OPCAT mandate), the Mental Health and Wellbeing Commission, District Inspectors, and health auditors. The monitoring function need to be able to determine whether the mental health services (as provided or practiced) respect the rights of mokopuna involved in compulsory treatment.

The Monitors should have powers to make recommendations that require responses, e.g. to ensure any harmful or degrading treatment they report on can be rectified in a timely manner by the health system. For example, the new legislation could have a provision for a relevant agency (eg DHB) to implement recommendations from the Ombudsman and OCC, and/or be required to report on them to the Ministry of Health and Māori Health Authority, who in turn should be required to report to the Minister or Parliament, the MHWC (copying in the Ombudsman and OCC). The feedback loop of: review, recommendations and improvement, needs to be confirmed.

The independent monitoring function must have public reporting requirements, to ensure transparency and accountability of the mental health system.

A key role for independent monitoring is a focus on community treatment orders and the oversight of those. In addition, other aspects of the mental health system should be subject to recommendations through thematic reviews, such as transition plans and associated service provision. Transition plans need to have oversight to ensure the ongoing efficacy of compulsory treatment. Services that support transition plans include: community organisations, schools and teachers, Oranga Tamariki social workers, and other community or health supports required in a transition plan for whānau (eg provision of at-home caregiving support, home health visits etc).

Ensuring complaints mechanisms are fit for purpose

Legislation needs to uphold existing, or enable new, complaints mechanisms, so mokopuna, and/or their caregivers, can report where services have contravened their rights, taking into account the compulsory nature of the treatment being offered. Complaint mechanisms already exist via District Health Boards (DHB), Health and Disability Commissioner, District Inspectors, and the Ombudsman and these need to be made accessible to mokopuna.

Treatment in mental health services

Individualised treatment plans

Legislation should provide for a system that is both non-discriminatory, and allows for bespoke treatment plans appropriate to the mokopuna whai ora, recognising any exacerbating factors.

In circumstances where there are complicating factors for mokopuna, such as family violence, homelessness or addiction, there should be prioritisation for secure places for those mokopuna. The legislation could require services to take into account exacerbating factors for mokopuna when managing waitlists.

Treatments should meet cultural needs. That means considering mokopuna as a holistic person, rather than considering their illness only in biomedical terms. All mokopuna receiving treatment should have access to child-friendly environments, services and cultural support.

Information sharing with mokopuna and whānau

Privacy of information should not be a barrier to supporting and providing information to mokopuna who are dependents of people undergoing compulsory treatment. Children of tangata whai ora can be negatively affected by their parents' treatment when they are not adequately informed and supported.

The legislation needs to allow for family and whānau-group engagement by medical and counselling professionals, because these relationships are critical to the ongoing support of mokopuna, implementing transition plans and accessing further treatments.

Requiring transition plans

The legislation should continue to require transition plans following treatment, before a mokopuna whai ora can be 'discharged' from a secure facility. The transition plans need to be operable, feasible, developed in partnership with mokopuna, whānau/caregivers, and agreed by any other agents required to provide support (eg community providers) to ensure the sustainability of treatment outcomes.

Transition plans are important for mokopuna, as well as adults receiving mental health care, but they need to have special provisions for mokopuna recognising their age, development, and often limited access to resources or power to make decisions (being dependent on others).

There also needs to be continuity of mental health and addiction services for mokopuna and their whānau who move outside their local communities if required. New Zealand has high rates of residential mobility, and instability of housing is associated with childhood outcomes.¹³ Whānau/caregivers can struggle to advocate for their mokopuna when faced with navigating rules of different DHBs. Transition plans should be applicable across DHB boundaries and there should be strong communication between service providers.

It is common for mokopuna in the care of Oranga Tamariki to be placed outside their local communities. When such a move occurs, another DHB is expected to pick up the provision of mental health, alcohol and other drug addiction services. However, this sometimes does not happen due to wait lists or other reasons, such as lack of permanency of placement, or poor communication between DHBs and handovers being inadequate. DHBs and Oranga Tamariki need to collaborate to ensure continuation of provision of mental health care to children in state care. All agencies should be collectively responsible for the treatment of mokopuna whai ora. How transitions are properly enabled through legislation needs to be a priority consideration.

Whānau, caregivers, foster parents, and others are often required to advocate for the implementation of transition plans. In order to achieve more sustainable treatments and rehabilitation in the community, greater supports are necessary for the whānau of mokopuna, to do this, alongside community supports and capacity to implement transition plans that emerge from compulsory treatments. While this support may not be able to be legislated for, if legislation requires transition plans to be made in consultation with mokopuna whai ora, their whānau, and community support systems (health providers, and others such as housing providers), then the plans are more likely to be effective.

Independent advocacy

Advocacy support is needed for mokopuna whai ora. In situations of compulsory treatment, medical professionals have a perspective based on medical information. However, whānau may also have a perspective and may be exhausted by the prior efforts of caregiving, may have depleted their emotional and other resources, and may need respite care with their own interests to defend. Who is the advocate for a mokopuna who may be suffering in mental distress?

¹³ "Residential mobility has been strongly associated with school-aged children's short-term academic, social and emotional problems and there is some support for a causal link. The relationship between mobility and child outcomes appears to be non-linear, with additional moves (or instability) being more detrimental than one or two moves" (page 80, Growing up in New Zealand Now We Are Eight).

The role to inform tangata whai ora of, and advocate for, their rights, eg their rights to a second opinion, or rights to appeal a decision, need to be enhanced. There are currently too few, and under resourced independent advocates (eg District Inspectors). Voluntary tangata whai ora (those under voluntary mental health treatments, rather than compulsory orders) should also have access to advocates who can explain their rights and advocate for their needs.

A compulsory treatment plan is necessarily an infringement of one's rights to liberty, and an advocate is a balancing agent to defend a person's rights. The advocate could also liaise with the whānau, supporting the right of mokopuna to maintain their relationship with whānau. Compulsory treatment orders can have an impact on family dynamics and put pressure on relationships. A specialist role to support decision-making on behalf of tangata whai ora, and to mediate with families, is an important contributor to recovery and the transition to ongoing wellness. The requirement for this kind of role can be embedded in legislation, including a high-level outline of the role.¹⁴

Limiting compulsory treatment

Legislation should articulate a "least restrictive approach" to mental health treatment. Never needing compulsory orders for mental health treatment would be the ultimate goal.

Some interim measures include the removal of indefinite treatment orders, having greater oversight over treatment decisions (eg by an independent monitoring function), and the shortest possible duration of compulsory treatment.

We know other submissions will be focused on these issues, and we endorse a least restrictive approach.

This submission has focused on issues the OCC thinks are important to mokopuna in compulsory mental health treatment. Systems that work well for mokopuna are urgent and complement progressive change for all tangata whai ora.

The next section of this submission answers the child-specific questions from the consultation document.

¹⁴ Guidelines for the role and function of district inspectors (health.govt.nz): <https://www.health.govt.nz/system/files/documents/publications/guidelines-for-role-function-of-district-inspectors-feb2012.pdf>

Questions from consultation document

Q46 How should compulsory treatment be applied to children and young people?

Mokopuna cannot be seen as separate from their whānau/caregivers (also referred to as guardians). Compulsory treatment provided in emergency situations should ensure respect for the relationships of mokopuna (children and young people) with their guardians.

Whānau should be informed and consulted at every stage of treatment. Mokopuna should be given opportunities to consent to treatment, consistent with Article 12 of the Children's Convention, in accordance with their developing cognitive development and mental capacities. Alongside efforts to seek the views of mokopuna as to their treatment, decisions should be made with their consent, in their best interests, and in partnership with their guardians. For more details see sections above.

Q47 How would mental health legislation specific to children and young people reflect te ao Māori?

Giving effect to Te Tiriti in all parts of the legislation means ensuring that mokopuna Māori have access to treatment and services that are kauapapa Māori designed and delivered. This requires that staff across all systems and services, Māori and non-Māori, are equipped to work with Māori and are able to understand tikanga needs, and draw on outside expertise as required. The agencies determining what services are to be provided should be required to consult with Māori and/or the Māori Health Authority should have a say in service provisions.

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

Where compulsory treatment is required, whānau should be engaged and involved at the earliest opportunity with the intention that this occurs prior to any decision on treatment. The legislation needs to make explicit a set of requirements that ensures this process of engagement is carried out in a whānau and mokopuna-centred

manner, that is authentic in the desire to gain agreement, and provides a clear path forward if there is no agreement.

Mokopuna have rights under article 12 of the Children's Convention to be included in decision making regarding their care. In some emergency situations, such as active psychosis this may not be possible at a particular point of time. However, the principle of consent and participation in decision making should be articulated in the legislation to uphold the rights of mokopuna. There is also a place for whānau and/or guardians to be consulted and have opportunities to agree to treatment plans, in accordance with the views of mokopuna and the long-term best interests of the mokopuna.

The rights of mokopuna to be connected with whānau must be upheld, and legislation should enable continued relationships during and after compulsory treatment.

Q49 What should the process be when staff & whānau disagree on treatment of mokopuna?

Compulsory treatment of mokopuna should only be required in times when urgent interventions are necessary. When there is disagreement as to ongoing treatment, the health system must recognise the need for mokopuna to be supported by family/whānau for the sustainability of any treatment plan for mokopuna.

The service providers must respect the views of family/whānau, and not be dismissive. The views of mokopuna should be given due weight. Engagement with mokopuna and whānau to achieve consensus on treatment should respect their cultural needs.

If the medical professional considers ongoing treatment to be essential for the safety of the tangata whai ora and others, but there is ongoing disagreement, there should be an option to have a second opinion from another independent professional. The Māori Health Authority should have a clear role to design any interventions, such as mediation, and define the cultural requirements, for example involving kaumatua.

Q50 What should supported-decision-making look like for children and young people?

Supported decision-making should involve fully informing both the mokopuna whai ora and their guardians, or other advocates, about all the options available to them, communicated in a manner that is appropriate to their age and maturity. This could be done by a specialist counsellor, a designated Māori specialist, a social worker or other professional or culturally appropriate person.

It means giving opportunities for collective discussion and decision-making that includes the perspectives of mokopuna in accordance with their developing agency and cognitive capacity. It means *not* dismissing someone's views because of their mental state, age, language barriers, legal status (e.g. in forensic situations), or intellectual disability or neurodiversity.

Supported decision-making may require specialist training of medical professionals in the art of listening, including child-friendly communication approaches, and understanding the perspectives of the mokopuna whai ora and their whānau, so conversations can be more respectful and reflective of collective consensus processes. While the legislation may not be the route to achieving this (which often depends on funding and time available for professionals to spend conversing and developing relationships), guidelines could be developed to support professional training, and mediation and decision-making between medical professionals and mokopuna/whānau, and the requirement for such guidelines could be in the legislation.