The rollback of Māori rights in the context of health partnership, research and mental health legislation

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ABSTRACT

This paper critiques recent policy and legislative developments in Aotearoa New Zealand, arguing that they represent a rollback of Māori rights in health, research and mental health law. The authors distinguish between inequality and inequity, emphasising that Māori experience disproportionate and avoidable disadvantages rooted in systemic factors. They challenge political narratives that frame equity-focussed approaches as race-based prioritisation, instead grounding their argument in Te Tiriti o Waitangi obligations and international human rights standards. The disestablishment of Te Aka Whai Ora – Māori Health Authority is identified as a key example of regression, with the United Nations Committee on the Elimination of Racial Discrimination expressing concern that this decision undermines Indigenous rights and health equity. The paper further critiques the new *Mental Health Act 2026*, highlighting the continued reliance on compulsory community treatment and seclusion despite evidence demonstrating limited effectiveness and disproportionate impacts on Māori. Drawing on national and international research, the authors argue that coercive practices are inconsistent with human rights frameworks, including the Convention on the Rights of Persons with Disabilities. They contend that the new legislation fails to deliver the transformational change envisaged in earlier policy commitments. As an alternative, the paper proposes the "community support commitment" model that would replace compulsory treatment with a rights-based, voluntary approach centred on supported decision making and service accountability. The paper concludes that without the legislation adopting the substantive reform required, current policy directions risk entrenching inequities and reversing progress towards equitable, culturally responsive and rights-based mental health care.

We are a group of non-Māori and Māori who undertake research together. We are often accused of being woke. This accusation appears to be an attempt to discredit our work by co-opting the term woke, which has its origins in being "awake" to systemic inequities and proactively engaging in efforts to address them.

Sometimes we think criticisms stem from a confusion between inequity and inequality—the difference being that inequality refers to measurable differences between groups or individuals, such as differences in income, health outcomes, educational attainment or access to resources. In contrast, inequity more directly focusses on fairness. It refers to differences in opportunities and outcomes that are unfair, avoidable or are rooted in systemic disadvantage, discrimination or bias. To be clear, our work is focussed on inequities because we believe this focus leads to equality.

The three-party coalition that currently governs Aotearoa New Zealand seems to lack a grasp of *inequity*. As the principal government funder of health research, the Health Research Council (HRC) receives an annual letter of expectations from the minister of health with updated signals for investment priorities. The letter of expectation for 2025/2026 sent from the Ministry of Health – Manatū Hauora to the HRC stated:

> "*My overarching expectation is that we are relentless in our pursuit of the delivery of more and better health services for New Zealanders. In doing so, I expect all health entities to put patient need at the heart of every decision made and to prioritise their efforts on the basis of need, not race.*"[1]

As principal investigators of several HRC-funded research projects, we can confirm that our priority population is Māori. However, this focus is not due to race, which is a discredited concept not used in public policy documents, but the well-known fact that Māori face the worst inequities in our country with regards to health, education and justice outcomes.

We assume this perspective—the prioritisation of Māori being based on race—is why the current

governing parties disestablished Te Aka Whai Ora – Māori Health Authority. Of course, the establishment of this body was due not only to the inequities that Māori face but also to obligations under Te Tiriti o Waitangi. Considering the principles of self-determination (tino rangatiratanga), partnership, equity, active protection and options in health policy, it seems Māori just got too close to the potential for the actual realisation of some of these. From our perspective, this disestablishment felt akin to book burning or land confiscation. That is why we were pleased to hear that this disestablishment was specifically included in a report to the United Nations Committee on the Elimination of Racial Discrimination (CERD) for their opinion.[2] In summary, the CERD expressed concern over the Government's decision to dismantle Te Aka Whai Ora and considered this action to constitute a rollback of Indigenous rights and health progress. The situation highlights a conflict between the Aotearoa New Zealand government's policy direction and international standards for Indigenous rights and health equity.

While there was no official media release, and very few domestic news outlets and networks that substantively focussed on the concluding observations of the CERD report, major international outlet *The Guardian* ran prominent coverage.[3] We find it flummoxing that an international outlet thought this landmark decision of the CERD was of sufficient significance to substantively report on, and yet most of those from our country and for whom the decision actually relates did not. *Scoop* acted as the hub for the publication of the press release of the Peace Movement Aotearoa,[4] which included reporting that:

> "*There was no official media release that the Minister for Justice would be travelling to Geneva to head the New Zealand delegation to speak with the Committee, nor any after the Concluding Observations were released.*
>
> *Deputy PM David Seymour described the Concluding Observations as 'absolutely laughable' and said the United Nations was 'a joke', while NZ First Minister Shane Jones asked in question time on 9 December … 'Is the Minister aware that a number of the people who sit on these UN pettifogging committees come from countries with far worse race relations than New Zealand?'.*"[4]

As a result, the press release conclusion was that it is:

> *"A useful time to reflect that New Zealand voluntarily joined the Convention, which requires all state parties to take immediate and effective action to end all forms of racial discrimination, as well as to eradicate racist ideas and practices … not to promote racial discrimination and divisiveness, and denial of basic human rights as the current government seems intent on doing."*[4]

In our opinion, it is a major concern that at least two of our senior governmental ministers have a perception of the United Nations that is not only negative but disparagingly negative. The United Nations is an international organisation founded in 1945 in the aftermath of the Second World War. Its creation reflected the world's urgent desire to prevent another global conflict and to build a stable international order. One of the main ways it was determined that this be most effectively done is by upholding human rights and international law. By not doing that, we contribute to breaches of rules, rights and obligations that help us avoid the conflict, unrest and harm we currently see on a global scale. We now give a case in point: the new *Mental Health Act 2026*. This *Act* illustrates the importance of centring human rights to reduce inequity and promote treaty compliance or, in contrast, the grievous consequences of not doing so.

Mental Health Act 2026

As authors, we collectively have many concerns about the new *Mental Health Act 2026*, but a few in particular we would like to focus on here are the retention of compulsory community care from the 1992 legislation, the continued allowance for the use of seclusion and the appropriate use of advance directives.

Our reviews of the evidence base have consistently shown that compulsory community treatment is not effective in reducing hospital readmission and improving mental health outcomes. Given that compulsory community treatment involves a significant breach of human rights, substantial evidence of benefit is needed to justify this measure. This evidence does not exist.

We find the ineffectiveness of community treatment orders concerning, given that Aotearoa

New Zealand's community compulsory treatment rates are exceptionally high by international standards, and are disproportionately used with tāngata whaiora Māori.[5] Compulsory community treatment is used nearly four times more often with Māori than non-Māori.

A major rationale for community treatment orders is to address the frequently expressed concern that patients discharged from compulsory inpatient care will disengage from treatment if there is no legal compulsion to receive it. We have seen this concern expressed by whānau, tāngata whaiora and mental health clinicians during our research. Whānau and tāngata whaiora have also told us that without the mechanism of the compulsory treatment order, tāngata whaiora will be unable to access support from mental health services. There is concern that disengagement will leave vulnerable individuals without support, resulting in deterioration in their mental health. If this is the case, services should provide the support for people to live their lives free of compulsion, rather than leaving them vulnerable. Support should not be contingent on compulsion. Services can support people voluntarily, following them on their recovery journey and allowing them to go at their own pace with or without the support of mental health services. Given the current pervasive issues of under-resourcing, understaffing and high thresholds for accessing treatment, voluntary community support will require a radical reimagining and resourcing of mental health services similar to that which drove deinstitutionalisation. We note that those subject to compulsory community treatment under the new legislation are essentially the same group of people subject to community treatment orders under the current *Act*. As such they have assigned clinicians and key workers and, at least in some cases, support from non-clinical support workers. Voluntary community support would see current clinical roles redefined, and perhaps a reassignment of resources to non-clinical support services. These are the sorts of aspirational goals that seemed to be anticipated by *Transforming Our Mental Health Law*[6] and which we suggest should drive further reform. Of note, a common theme reflected through the profiling of person-centred and rights-based services by the World Health Organization is that in many cases these services show lower costs of service provision than comparable mainstream services.[7]

There is also the issue of seclusion. Since the introduction of the seclusion reduction policy in 2009, the number of people secluded has decreased by 48%. In contrast, the number of Māori secluded has decreased by 18% over the same period.[5] Research into variation in seclusion rates across Aotearoa New Zealand mental health services has found that these rates were not influenced by socio-demographic and clinical factors.[8] As a result of this finding, the authors concluded that the variation may be better explained by differences in service delivery models and practice approaches. This is a classic example of what we discussed earlier: the research findings show that this disparity is not based on ethnicity as it might mistakenly be thought but rather stems from systemic disadvantages—inequities that arise from the way these service delivery models and practice approaches operate, creating barriers to culturally safe and appropriate care.

While it is commendable that the new legislation heralds the end of seclusion for children and young people, it does not amount to a complete legislative prohibition of seclusion for all adults. There is not even a sunset clause including a mandate and a time frame for complete prohibition, as advocated for by the Green Party, Te Pāti Māori and the Labour Party.[9] Arguably, important human rights issues like this should not be politicised, and a cross-party consensus should be pursued. Human rights are not a right-wing, centre or left-wing perspective; they are inalienable.

These issues exemplify some of the reasons the United Nations Committee on the Convention on the Rights of Persons with Disabilities (CRPD) is calling for the abolition of seclusion and of substitute decision making, including compulsory community treatment. The CPRD specifically criticised the *Mental Health Act 1992* for such issues and recommended that it be amended to comply with the CRPD. That criticism will continue given that these issues have not been addressed through the new legislation. The General Comment on Article 12 of the CRPD makes it clear that the development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with Article 12 of the Convention.[10]

It is notable that Te Aka Matua o te Ture | Law Commission's recent report on adult decision-making capacity law makes extensive reference to the CRPD and makes recommendations for robust provisions to realise supported decision making in practice.[11] If the Law Commission's recommendations are adopted then mental health legislation will be out of step with

general decision-making capacity legislation.

We provided a solution for transformational change through repeal and replacement

One of the main recommendations of *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*[12] was to repeal and replace the *Mental Health Act 1992*. They specified that any new act needed to reflect a human rights–based approach, align with modern models for mental health care and minimise the use of compulsion, seclusion and restraint. That recommendation was accepted and prioritised by the Government.

In 2021, the Ministry of Health released a discussion document that called for transformational change to Aotearoa New Zealand's mental health legislation.[6] In particular, the discussion document set a highly aspirational agenda: legislation that would be based on a Te Ao Māori worldview and be consistent with Aotearoa New Zealand's commitments to human rights as expressed by the CRPD, would reduce the reliance on compulsory treatment and coercive intervention and would address inequities in the use of mental health legislation.

Unfortunately, the transformational aspects of the *Mental Health Act 2026* have mostly been incorporated as principles. One of the leading international research teams (the FACTORS team, see: https://www.latrobe.edu.au/research/ceri/documents/New-Zealand-Submission-FINAL.pdf) on mental health legislation in action has identified that the inclusion of principles in legislation appears to do little to alter coercive practices. Hence, in their submission on our *Mental Health Bill*, the FACTORS team concluded that if the *Bill* were to pass in its current form, as it has done, it is unlikely to have a significant impact on current practice or on reducing the use of compulsory community care. Recent research from Norway[13] tells us why. Norway's legislative attempts to reduce the rates of compulsory community treatment have not been successful when clinicians have decision-making discretion. This is because clinicians resort to paternalistic, risk-based practice rather than following the intent of legislation. The implication is that if legislation is to influence clinical practice, it needs to be highly restrictive, or perhaps to remove the option of compulsory community treatment.

We conclude that the *Bill* lacks the transformational change recommended by the CRPD, by *He Ara Oranga* and in the Ministry of Health's discussion document.

Being concerned about the failure of the proposed legislation to provide the transformative change anticipated in the Ministry of Health's 2021 discussion document[6] but aware that a truly significant change (such as the complete abolition of substitute decision making) would never gain approval, we proposed and sought cross-party support for an alternative position on voluntary community support. We wondered if providing an example of a solution might assist in envisaging other ways of supporting tāngata whaiora beyond coercion. We proposed that the provision for compulsory community care (s77, community care orders) be removed from the draft *Bill* and replaced with a provision we have called the "community support commitment" (CSC). The CSC would introduce a positive right for tāngata whaiora to receive support from a community mental health service. The CSC would be a statement of the mental health service's commitment to remain engaged with the tāngata whaiora for 1 year following a period of compulsory treatment in the hospital. The CSC would retain the provisions in the *Mental Health Bill* for a holistic support plan, the involvement of a support person appointed by the tāngata whaiora and the creation/update of an advance directive developed independently of the mental health service. Crucially, the CSC would be binding for the mental health service but voluntary for the consumer.

We proposed that this amendment would achieve three main aims of the *Mental Health Bill*. Firstly, it would ensure that people with high levels of mental health needs are well supported on discharge from the hospital. Secondly, it would eliminate Aotearoa New Zealand's use of compulsory community treatment and significantly reduce the overall use of compulsion in Aotearoa New Zealand's mental health services. Thirdly, it would also address inequity, particularly for Māori who are disproportionately subject to compulsory community treatment under the existing legislation. However, that proposal was rejected, and was mischaracterised in the final parliamentary debate as leading to the potential neglect of tāngata whaiora.[14]

The advance directive component of the CSC

There are several components we recommended to support the CSC. However, these alone would not be transformative unless the bold

step of removing the provision for compulsory community treatment was taken. One supportive mechanism is advance directives.

Our previous work (funded by an HRC research grant) involved tāngata whaiora (including whānau) and service providers (such as clinicians, healthcare support workers/assistants, Māori and other cultural advisors) working together to identify, articulate and prioritise interventions that facilitate supported decision making.[15] We found that pre-event planning and post-event debriefing were strongly endorsed by all stakeholders, and especially prioritised by Māori, Pacific people, family and consumer groups. We then built on this mandate and, with the support of the HRC, partnered with Health New Zealand – Te Whatu Ora Lakes and Waikato to create and implement advance directives in a project called Te Kete Rongomau.

In a Te Kete Rongomau study, together with a co-produced approach (involving a collective composed of the diverse voices of tāngata whaiora who experience mental distress alongside those who work and research mental health services), we were guided by a Te Tiriti o Waitangi–led approach from the start, with the project establishing a leadership team of Māori and non-Māori and drawing on Matike Mai Aotearoa[16] to conceptualise Te Tiriti o Waitangi relationships in constitutional terms, outlining three spheres of influence over decision making: rangatiratanga, kāwanatanga and relational. The rangatiratanga sphere includes Māori governance over people and places. The kāwanatanga sphere represents Crown governance. An overlapping and larger relational sphere reflects the space where Māori and the Crown join in decision making over mutual concerns. The reason for this, other than our obligations under Te Tiriti o Waitangi, is that the over-representation of Māori in compulsory treatment means that Māori interests are central to this project (for further information, please visit: www.teketerongomau.com). Had our application to do this work been submitted after the Ministry of Health's letter of expectation for 2025/2026 had been sent to the HRC, as mentioned above, our proposal likely would not have been successful. We remain concerned that our research into a key approach to facilitate supported decision making, along with much other human rights–related research, will halt until this expectation changes.

In its report to Parliament on the revised legislation, the select committee stated our provisions for the CSC to replace compulsory community treatment were supported by the Green Party, Labour Party and Te Pati Māori.[9] Yet again, we reiterate that important human rights issues like this should not be politicised, and a cross-party consensus should be pursued. To restate, human rights transcend the political spectrum, serving as fundamental entitlements for every individual.

The rollback has continued with the new mental health legislation

To reiterate, the UN has warned that Aotearoa New Zealand is regressing on Indigenous rights and health progress. As we previously reported, the Aotearoa New Zealand Government's decision to dismantle the Māori Health Authority is a key example. We argue that the new mental health legislation will take us even further backwards, undoing positive progress for people experiencing mental distress—progress that took years, if not decades, to make. What all this ultimately means is that unless the inequities currently faced by Māori are addressed, these differences that are unfair, avoidable or are rooted in systemic disadvantage, discrimination or bias are going to continue and worsen. We are academics and advocates awake to systemic disadvantage and oppression. Our research and analysis reaffirm the need for transformational change to reduce inequities and support human rights.

COMPETING INTERESTS
AJOB was co-chair, Ministry of Health – Manatū Hauora Expert Advisory Committee on Reform of Mental Health Legislation, 2022–2023.

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