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MENTAL HEALTH FOUNDATION OF NEW ZEALAND: SUBMISSION TO THE UNIVERSAL PERIODIC REVIEW RELATING TO THE SITUATION IN NEW ZEALAND OF PEOPLE LIVING WITH MENTAL ILLNESS

Introduction

1. The Mental Health Foundation of New Zealand (MHF) is a charitable trust, established in 1974, that promotes mental health and wellbeing throughout Aotearoa New Zealand.
It is the largest and longest standing nongovernmental organisation promoting the concerns of mental health consumers and advocating on their behalf. Its objectives include promoting the mental health and wellbeing of the inhabitants of New Zealand of whatever ethnic origin, age, gender or sexual orientation and taking all measures designed or likely to prevent the incidence of mental ill health in the community. MHF aims to reach a wide range of people and organisations with information and resources and work with them to develop capacity for autonomy and self determination, reduce discrimination and increase equity and social inclusion through advocacy, education, policy and practice.

2. The Foundation welcomes this opportunity to contribute to the UPR. The submission is based on the work done over the relevant period by MHF and other NGOs and in collaboration with agencies such as the Health and Disability Commission, the Human Rights Commission and the Ministry of Health through the *Like Minds Like Mine* programme.

I. BACKGROUND AND FRAMEWORK

A. Scope of the international obligations

3. New Zealand has a good record of ratifying international instruments. As a general principle it endeavours to ensure that its domestic legislation complies with the international standards before ratification. As a result it records few reservations and actively works to remove any it has made.

4. New Zealand has ratified most of the instruments that are relevant for people with mental illness. Most recently, it ratified the United Nations Convention on the Rights of People with Disabilities (the Disability Convention) with no reservations after playing a significant role in its development. During the period under review New Zealand also ratified the Optional Protocol to the Convention against Torture and established a number of national preventive mechanisms to give effect to it.

5. In anticipation of its ratification of the Disability Convention, New Zealand carried out a National Interest Analysis to identify domestic legislation that was non-Convention compliant. The Disability (United Nations Convention on the Rights of Persons with Disabilities) Bill 2008 (inter alia) amended all legislation which contained provisions that reflected the stereotypical assumption that a person was incapable of performing certain public or fiduciary roles because they were mentally disordered.

B. Constitutional and legal framework

6. New Zealand does not have an entrenched constitution. Its constitutional arrangements consist of a number of pieces of legislation that can be repealed by a simple majority. Social and economic rights, which are reflected mainly in policy and practice, are particularly vulnerable. The ongoing international financial situation increases the likelihood that people such as those living with mental

illness – already among the most vulnerable - will suffer more than most in these areas. This is especially so as regards to the indigenous population as Maori are already disproportionally represented in mental illness statistics[1], experience a poorer standard of living, higher unemployment, lower educational achievement[2], lower social economic status and consequently poorer health.

This situation would be greatly improved if there was more comprehensive, statutory protection for social and economic rights.

7. The New Zealand Bill of Rights Act 1990 has been described as having quasi- constitutional status[3] but it is only recently that it has been accepted that provisions such as the right to be treated with dignity and humanity if detained[4]or not to be subjected to cruel or degrading treatment[5], applied to people undergoing compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MH(CAT) Act).

8. The MH(CAT) Act itself was designed to comply with the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles) and for the most part it meets many of the necessary standards. However, when the MH(CAT) Act was reviewed for consistency with the Disability Convention anomalies were identified in both the legislation itself – for example, there is inadequate provision for patients to be informed of the reason for their continuing detention – and in how aspects of the legislation were implemented in practice – for example, the lack of a genuinely independent second psychiatric opinion where a patient refuses consent to the administration of electro-convulsive therapy.

9. A further problem with the legislation is that it is silent on the issue of capacity. The assumption being that if a person is committed under the MH(CAT)Act then they are automatically deemed to be incompetent to consent to treatment and they can be treated against their will. For example ECT was used on 160 people who were not able to consent to treatment during 2011[6].

10. MHF considers that, given New Zealand's ratification of the Disability Convention and improvements in best practice internationally, consideration should be given to reviewing of New Zealand's mental health law and other related legislation.

II. PROMOTION AND PROTECTION OF HUMAN RIGHTS ON THE GROUND: IMPLEMENTATION OF THE INTERNATIONAL HUMAN RIGHTS OBLIGATIONS

Equality and non-discrimination

11. For people with experience of mental illness, social exclusion and discrimination has been endemic in New Zealand society and continue to create barriers to their ability to live successful, fulfilling lives. In 1996, an inquiry into mental services[7] highlighted the need to reduce stigma and discrimination against people with mental illness in New Zealand. Two significant outcomes of the Inquiry were the establishment of the Mental Health Commission and a project by the Ministry of

[1] Oakley Browne M. A., Wells J. E., & Scott K. M. (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health
[2] Mental Health Commission. (2011). *Measuring Social Inclusion. People with experience of mental distress and addiction*. Wellington: Author.
[3] Rishworth et al. *The New Zealand Bill of Rights Act 1990* OUP (2003) at 2
[4] Section 23(5) NZBORA
[5] Section 9 NZBORA
[6] Ministry of Health. (2012). *Office of the Director of Mental Health: Annual Report 2011*. Wellington: Author.
[7] Ministry of Health. (1996). *Inquiry under s.47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minster of Health Hon Jenny Shipley (the Mason Inquiry).* Wellington: Author.

Health – *Like Minds Like Mine Project to Counter Stigma and Discrimination Associated with Mental Illness*.

12. The Government is to be commended on the success of the *Like Minds* project and the accompanying advertising campaign. Both projects were the recipient of a number of prestigious awards and have succeeded in bringing about significant attitudinal change[8]. However, stigma and discrimination against people with mental illness persists[9] and people with mental distress feel less included in society than others which negatively impacts them and their communities across many life domains[10].

13. The establishment of the Mental Health Commission was a positive outcome of the Mason Inquiry. Established under the Mental Health Commission Act 1997, the Commission was subject to a sunset clause which would have seen its demise in 2007 but was extended to 2015 by an amendment in 2007. MHF supported and welcomed this extension but had concerns about the Commission's mandate and limitations. In 2012 following the result of the Crown Entities Amendment Bill, the Mental Health Commission has been disestablished as a Crown Entity and a single Mental Health Commissioner has become a deputy in the Health and Disability Commissioners Office.

14. The Commission does not have oversight of the operation of the Act. MHF considers that the needs and requirements of people with experience of mental illness would be better served if the Mental Health Commission or the Office of the Health and Disability Commissioner's mandate was extended to give oversight of the operation of the MH(CAT) Act and to allow the Commissioner to deal with complaints from individuals about their treatment if detained under the Act.

Right to life, liberty and security of the person

15. In 2004 the Human Rights Commission published Human Rights *in New Zealand Today: Nga Tika Tangata O Te Motu.* This was the first comprehensive review of human rights in New Zealand and formed the basis for the subsequent Action Plan for Human Rights. While mental health services attracted some positive feed back, the use of compulsion was criticised along with the inappropriate use of seclusion.

16. The Action Plan prioritised seclusion as an issue that needed for further attention and undertook to collaborate with the Mental Health Commission on a project to clarify the human rights issues around the use of seclusion. The resulting paper can be found at http://www.hrc.co.nz/hrc_new/hrc/cms/files/documents/17-Jun-2008_10-14-55_Seclusion_Report_FINAL_16June_2008.pdf

17. While there have been some attempts to change how seclusion is used in New Zealand, the use of seclusion remains high and varies between District Health Boards[11]. For instance while the rate of number of people placed in seclusion has reduced since a seclusion reduction policy was introduced in 2009, in 2011, of the 6072 patients who spent time in New Zealand mental health units, 14%

[8] Mental Health Commission. (2004). *Journeys Towards Equality: Taking Stock of New Zealand's Efforts to Reduce Discrimination against People with Experience of Mental Illness*. Wellington: Author.
[9] Peterson, D., Pere, L., Sheehan, N. & Surgenor, G. (2004). *Respect Costs Nothing: A survey of discrimination faced by people with experience of mental illness in Aotearoa New Zealand.* Auckland: Mental Health Foundation.
[10] Mental Health Commission. (2011). *Measuring Social Inclusion. People with experience of mental distress and addiction*. Wellington: Author.
[11] Ministry of Health. (2012). *Rising to the Challenge. The Mental Health and Addiction Service Development Plan. 2012-2017*. Wellington: Author.

experienced at least one seclusion event and Maori were more likely to be secluded that any other ethnic group[12]. The use of seclusion also varied widely according to geographic location.

18. Given the potential abuse of human rights that can result from the misuse of seclusion, MHF considers it should either be eliminated entirely or there should be a stronger commitment to ensuring its use is restricted to very limited, clearly specified circumstances and used only in extreme situations where it is the least intrusive way of managing dangerous behaviour.

19. Electro-convulsive therapy (ECT) is used for therapeutic purposes in New Zealand. The conditions under which it can be administered are found in the MH(CAT) Act. Under section 60(a) ECT may be given with the person's written consent. If the person does not consent, ECT may still be administered if it is considered to be in their interest by a psychiatrist appointed by the Review Tribunal[13].

20. There is no requirement that the opinion needs to be supported by any evidence. Treatment does not even need to be in the patient's best interests. It may simply be clinically expedient and overlook other more benign treatments that are less intrusive but have the same effect. Further the psychiatrist appointed to provide the second opinion may often not be truly independent.

21. In response to public concern there have been two reviews of the administration of ECT in New Zealand over this period[14]. Both made it clear that it was not acceptable to use the MH(CAT) Act to administer ECT to competent patients who did not consent and recommended that the Act should be amended to ensure that ECT is only administered with consent or at the very least more stringent controls are established either by ensuring a truly independent second opinion or developing an objective best interests test. To date this has not happened.

The Mental Health Foundation provided a submission in 2007 proposing that ECT should never be used without the informed and genuine consent of the recipient.

23. Part 8 of the MH(CAT) Act sets out the provisions applicable to patients under the age of 17 years. In general, other than requiring the consent of guardians, a prohibition against brain surgery and the use of a child psychiatrist, patients under 17 are subject to the provisions of the MH(CAT) Act in the same way as any other patient. There is no requirement that children should be kept separate from adults and there are significant disparities in levels of funding and services available for infants, children and young people in comparison to the adult population[15].

Right to work

24. The ability to access and retain employment is a critical factor in recovery from mental illness but a combination of discrimination and stereotypic assumptions means that people with mental illness face significant barriers to employment and inadequate access to services and support to enable them to overcome the barriers[16]. A 2011 study found the people with symptoms of mental distress are significantly less likely to be employed and be satisfied with their job than people with no symptoms,

[12] Ministry of Health. (2012). *Office of the Director of Mental Health: Annual Report 2011*. Wellington: Author.
[13] Section 60(b) MH(CAT) Act
[14] Ministry of Health. (2004). *Use of Electroconvulsive Therapy (ECT) in New Zealand: A Review of the Efficacy, Safety and Regulatory Controls* Wellington: Author and an inquiry by the Health Select Committee *Electroconvulsive Treatment* in 2007.
[15] The Werry Centre. (2011). *2010 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. Auckland: Author.
[16] Mental Health Commission. (2011). *Measuring Social Inclusion. People with experience of mental distress and addiction*. Wellington: Author.

and this decreases with severity of symptoms (68% for people with no symptoms, 51% for mild symptoms, 36% for moderate symptoms and 27% for severe)[17].

People with long term mental illness problems are amount the most impoverished groups in the community and are three times more likely to be in debt than others.

25. Generic services to assist people gain and keep employment have not performed well for people with mental illness and public policy initiatives tend to be poorly integrated and thought through. Government departments need to develop a shared information base (with disaggregated data) to develop effective employment solutions.

Maori

26. Major strategies[18] have been developed to address the situation of Maori, but Maori continue to be hospitalised for mental disorders at much higher rates than non-Maori. Maori men, in particular, are more likely than their non-Maori counterparts to be hospitalised. Maori experience the highest level of mental disorder for overall disorders and for disorder group. Maori are also more likely to experience inpatient admissions and compulsory treatment[19].

27. While socio-economic factors play a role in this, they still do not explain it. To ensure better outcomes for Maori with serious mental illness is required about the nature and impact of barriers to access of services and about the effectiveness of services[20].

KEY NATIONAL PRIORITIES, INITIATIVES AND COMMITMENTS

MHF suggests that the following commitments would improve the human rights of people with mental illness:

- Reviewing and amending the mental health legislation to ensure it recognises that people with mental disorder do not automatically lose their capacity to consent to treatment;
- Obtaining a commitment to phasing out the use of seclusion with a target date and KPIs;
- Amending the MH(CAT) Act to ensure that ECT is genuinely administered with informed consent;
- Better resourcing mental health services for children and young people and interagency strategy;
- Encouraging government departments to develop a shared information base interagency strategy to develop effective employment solutions for people with mental illness;
- Further investigate the reason for the disparities in hospitalisation of Maori and prioritise access to and effectiveness and responsiveness of community and primary services.

[17] Mental Health Commission. (2011). *Measuring Social Inclusion. People with experience of mental distress and addiction*. Wellington: Author.
[18] For example, Ministry of Health. (2006). *Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015* Wellington: Author.; Ministry of Health. (2008). *Te Puawaiwhero – The second Maori Mental Health and Addiction National Strategic Framework.* Wellington: Author.
[19] Ministry of Health. (2012). *Rising to the Challenge. The Mental Health and Addiction Service Development Plan. 2012-2017.* Wellington: Author.
[20] Baxter, J. (2008). *Maori Mental Health Needs Profile: A Review of the Evidence.* Wellington: Ministry of Health