



# Submission to the Government Inquiry into Mental Health and Addiction



**NZ  
Human  
Rights.**

Human Rights Commission  
Te Kāhui Tika Tangata

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## Summary

Further to the meeting with members of the Inquiry Panel on 2 May 2018, the Human Rights Commission provides this written submission to assist the Panel with its deliberations. The Commission's position can be briefly summarised as follows:

1. Four fundamental principles must underpin the approach to mental health and addiction within Aotearoa. These are:
  - a. An holistic approach is required for building and maintaining mental wellness and general wellbeing at both an individual and community level. This means ensuring that basic human needs such as housing and food are met as well as making sure that people live free from violence, abuse and bullying. The long term, and often intergenerational impacts, of social stressors and trauma should not be underestimated. These root causes of mental distress and addiction must be addressed.
  - b. Planning, delivery and provision of mental health and addiction services must be genuinely consumer centric and consumer driven.
  - c. Approaches and responses to mental health and addiction must be fully inclusive and should reflect, value and support people of all ages, sex, sexual orientation, gender identity, disability, religion, race, colour and ethnicity.
  - d. The legal, policy and funding frameworks supporting mental health and addiction approaches must be consistent with domestic and international human rights obligations, including the United Nations Convention on the Rights of Persons with Disabilities and the Treaty of Waitangi.
2. The Commission's position is that current arrangements fall well short of these requirements and significant transformational change is required, as outlined below.

### Consumer Centric and Consumer Driven Approach.

3. The Universal Declaration of Human Rights recognises the inherent dignity, and the equal and inalienable rights, of every member of the human family. Personal dignity is central to any discussion about mental health and addiction.
4. Normative approaches and prejudice against those who experience mental health conditions contribute to a society where mental health and addiction issues are often treated as embarrassing, shameful or a result of personal failure or character deficiencies. These attitudes inhibit people from seeking assistance and support and contribute to the stress experienced by those who are touched and affected by these conditions.
5. Ultimately, improved mental wellbeing at an individual and community level will require a change in mindset about how we view mental wellness and general health. It requires an inclusive approach that values diversity of thought and behaviour and demonstrates compassion and understanding towards those who are struggling or perceived as "different". Combatting fear, intolerance and prejudice are just as important as building new systems and developing new approaches and funding models.

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6. Alongside societal change it is necessary to harness the lived experiences of service users to develop a truly inclusive and responsive system. The approaches most likely to be acceptable for consumers and most successful in improving outcomes and general wellbeing are those that are developed with, and alongside, those who are most deeply affected.
  7. A human rights approach emphasises participation and empowerment of individuals and supports active involvement in design and implementation of processes and actions that affect them. It is derived from the Universal Declaration of Human Rights – human centred design is at the heart of the human rights approach. The approach requires action to be taken in a non-discriminatory and transparent manner and includes accountability processes to help ensure that those who have duties to discharge fulfil their responsibilities to an acceptable standard. Participation is particularly important for those who are most vulnerable and disenfranchised – including marginalised groups and those who face socio-economic, attitudinal and cultural barriers that might hinder their active involvement in matters that affect them.
  8. For a significant portion of New Zealand's Maori population, this is a particular concern. Maori are disproportionately represented in negative health statistics, including those relating to mental health and addiction. They are also disproportionately represented in poverty statistics and those related to poor educational achievement and violence and abuse (both as victims and offenders) all of which can have a negative impact on mental wellbeing.
  9. In 2016, Maori were 3.6 times more likely than non-Maori to be subject to a community treatment order and 3.4 times more likely to be subject to an inpatient treatment order.<sup>1</sup> Maori make up 16% of the population but comprise 27% of all mental health service users.<sup>2</sup>
  10. In the 2016-17 year 606 New Zealanders took their own lives. Overall, the suicide rate per 100,000 people is 12.64. For Māori the rate is 21.73 per 100,000 people. The suicide rate of Māori young people is even more alarming, at 2.8 times higher than that of non-Māori youth.<sup>3</sup> New Zealand's youth suicide rate of 15.6 per 100,000 is the highest among OECD countries.<sup>4</sup>
  11. At a population level, Maori bear a disproportionate burden of mental health related mortality and morbidity. In accordance with the Treaty of Waitangi and international human rights frameworks Maori have the right to take a lead role in the development of solutions and frameworks relevant to improving health and wellbeing. Maori must be at the centre of designing, implementing and providing solutions. This issue is discussed in more detail below

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1 Office of the Director General of Mental Health Report 2016 at 25.

2 Ibid.

3 People's Mental Health Report (2017) at 19.

4 FN:UNICEF, Building the Future, Children and the Sustainable Development Goals in Rich Countries, p. 22 [https://www.unicef-irc.org/publications/pdf/RC14\\_eng.pdf](https://www.unicef-irc.org/publications/pdf/RC14_eng.pdf)

- a. Genuinely consumer driven and consumer centric
- b. Consumers and service users have pivotal, not ancillary, roles in terms of individual support, care and treatment decisions as well as in developing, funding and overseeing the wider systems.
- c. The systems and processes in place will reflect, value and support the diversity of individuals – irrespective of personal characteristics such as age, ability, sex, gender identity, sexual orientation, race, colour or religion.
- d. The lexicon used by service providers, and more generally within the community, will be supportive and inclusive and not promote marginalisation, ostracism or blaming of those who need assistance to attain or maintain good mental wellbeing.
- e. The system will recognise and affirm the place of the Treaty of Waitangi in Aotearoa and enable the development and implementation of culturally appropriate approaches by Maori, for Maori, in line with their rights to rangatiratanga (self determination) over their health and wellbeing.
- f. Transformational options for devolution of service development and commissioning, funding, service delivery and general oversight mechanisms to consumer led agencies should be explored, in consultation with service users and other stakeholders. A brave and significant paradigm shift is required to maximise the input of consumers at every level of the system and to ensure a move away from token and piecemeal consultation with input being “tacked on” to existing outdated funding and delivery mechanisms. A completely new, consumer centred, model is required.

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## *The Human Right to Health*

12. The right to health is a fundamental human right that has been recognised in a number of international treaties and conventions that New Zealand has ratified.<sup>5</sup> People do not have an enforceable right to be healthy. The right encompasses access to timely, acceptable and affordable healthcare of an appropriate standard and requires the State to generate conditions in which everyone can be as healthy as possible. The right is a component of the adequate standard of living and extends to underlying determinants of health such as access to food and water, healthy housing and sanitation. The State is required to take progressive steps, to the limit of its available resources, to ensure the highest possible standard of physical and mental health for its population.<sup>6</sup> It must do so in a non-discriminatory and transparent manner.
13. It is essential for the human right to health to be explicitly recognised in relevant regulation, strategy and policy. It is not an optional extra or an “add on”.<sup>7</sup> A human rights based approach, grounded in concepts of individual dignity and autonomy, should be a cornerstone of any government’s strategy to improve mental wellness and general wellbeing.

**14. The Commission urges the Panel to explicitly adopt the human right to health as a guiding principle for its report and any related recommendations.**

## *Sustainable Development Agenda.*

15. New Zealand has endorsed the United Nations 2030 Sustainable Development Agenda. The agenda envisages a better world where physical, mental and social wellbeing are assured. The agenda is supported by 17 globally agreed goals, each supported by detailed targets and indicators. Goal 3 is to “ensure healthy lives and promote wellbeing for all at all ages”. Targets such as 3.4 (prevention, treatment and promotion of mental health and wellbeing) and 3.5 (strengthening the prevention and treatment of substance abuse, including narcotic drug use and harmful use of alcohol) are particularly relevant to the terms of reference of the Inquiry Panel.
16. The SDG agenda prioritises the collection of high quality data, disaggregated by vulnerable groups, to ensure that progress towards implementation is accurately tracked and monitored. The Commission supports this objective but also notes the need to ensure that individual privacy and personal information is appropriately protected during data collection and analysis. This is necessary to ensure that people are not deterred from seeking assistance or support because of concerns about unnecessary access to their personal health details at an individually identifiable level.

## *Convention on the Rights of Persons With Disabilities*

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<sup>5</sup> Most significantly, Article 12 of the International Covenant On Economic, Social and Cultural Rights.

<sup>6</sup> See World Health Organisation Fact Sheet available at <https://www.ohchr.org/Documents/Publications/Factsheet31.pdf> and Article 12 International Covenant on Economic, Social and Cultural Rights

<sup>7</sup> Note for example the consequences of the Ministry of Health’s failure to adopt a non discriminatory and human rights complaint approach to the payment of family members of disabled people *Spencer v AG* [2016] NZHC 1650, [2016] 3 NZLR 513, (2016) 10 HRNZ 731 [2016] NZHC 1650, [2016] 3 NZLR 513, (2016) 10 HRNZ 731

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17. The Convention on the Rights of Persons with Disabilities (CRPD) is highly relevant to the Panel's Terms of Reference. The CRPD takes a social rather than medical approach to disability. The Convention emphasises the importance of non-discrimination and active participation and imposes specific obligations in relation to awareness raising activities, combatting of stereotypes, and ensuring equality before the law.
18. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. There are some people who experience mental health or addiction challenges who will not come within this definition, particularly where the issues or conditions that they experience are temporary or transient. However, the principles outlined in the CRPD support good people centred practice generally, and it is not unusual for disabled people to also experience mental illness. There are strong crossovers between disability, mental health and suicide. Mental health matters can constitute a primary 'disability for definitional purposes, but mental health concerns can also become a secondary disability, caused or aggravated by social pressures around the primary disability
19. Article 12 of the CRPD provides that state parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. The article acknowledges that some people will require support to exercise this legal capacity and an emphasis is placed on the importance of supported, rather than substitute, decision-making. Substitution of another individual's view, or making decisions in the "best interests" of someone else are not permissible under the CRPD.
20. Some people will require extra supports in order to express their will and preferences and it is essential that adequate resources are in place for this to happen effectively. Practical options that could be considered to improve Article 12 compliance include the training and funding of health navigators and increased access to peer support workers with direct lived experience who can walk alongside service users.
21. Article 14 (Liberty and Security of the Person) provides people with the right to be free from involuntary detention, for example in a mental health facility, and that they should not be forced to undergo mental health treatment against their wishes. The UN Committee on the Rights of Persons with Disabilities has noted that this is one of the most "precious" rights to which everyone is entitled.<sup>8</sup>
22. Deprivation of liberty and coercive treatment based on the existence of a disability, including a mental disability, are inconsistent with the CRPD.

### *Seclusion and restraint*

23. Research commissioned by the Commission in 2017 highlighted concerns about the use of seclusion and restraint in New Zealand detention settings, including within mental health services.<sup>9</sup> International expert Dr Sharon Shalev noted the following:

- i. particular concern about the use of seclusion and restraint in relation to people

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<sup>8</sup> CRPD Committee 'Guidelines on Article 14 of the CRPD' September 2015, p1.

<sup>9</sup> Shalev, "Thinking outside the Box: A Review of Seclusion and Restraint Practices in New Zealand" 2017.

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experiencing mental illness (noting that this was prohibited under the Mandela Rules<sup>10</sup>);

- ii. seclusion and restraint not always being used as a “last resort” and in some instances being utilised for lengthy periods;
- iii. seclusion occurring in stark physical environments with patients having little or no control over their environment;
- iv. lack of meaningful activities or access to personal belongings<sup>11</sup>.
- v. individuals requiring urgent psychiatric assistance being detained in police cells due to a lack of appropriate alternatives.

24. While applauding the Ministry of Health and individual District Health Boards for their commitment to policies aimed at reducing, and eventually eliminating, seclusion and restraint, Dr Shalev noted that this commitment must be supported by a reassertion of why seclusion needs to be minimised in the first place. This being that it is damaging, inappropriate, not conducive to the therapeutic relationship between a consumer and caregivers and because it has no therapeutic value.<sup>12</sup>

**25. The Commission urges the Panel to support the elimination of coercive treatment, including the use of seclusion and restraint, and proscribe specific times frames by which this must occur**

#### *United Declaration on the Rights of Indigenous People*

26. Indigenous concepts of health encompass individual and collective wellbeing, and are interconnected to the realisation of a range of rights, including self-determination, development, culture, language, land and the natural environment. The right to health for indigenous peoples is affirmed in articles 21, 23, 24 and 29 of the UN Declaration on the Rights of Indigenous Peoples (UNDRIP). Article 22 emphasises the need for specific focus on children and young people, as well as women, older people and disabled people in the implementation of the Declaration.

27. The right to health is reflected and affirmed in the Treaty of Waitangi (the Treaty). The human rights obligations contained in the Treaty include good faith cooperation and shared decision making; protection of rangatiratanga (self-determination) and taonga (treasured possessions, tangible and intangible, including such things as: culture, language, land and health) and participation in society on an equal basis to others.

28. Alongside the human rights instruments which protect the universal right to health, the Treaty and UNDRIP affirm the rights of Maori, as New Zealand’s indigenous people, to health equity, participation in the development of health services and programmes, traditional health practices, medicines and resources.

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<sup>10</sup>Ibid at p 19.

<sup>11</sup>Supra, 4 at pp 36-38.

<sup>12</sup>Ibid, at 59.

29. The Commission has particular concerns about the ability of prison inmates and other detained people to access appropriate mental health supports. Those who are incarcerated are unable to independently access support and treatment and are reliant on the State to ensure that it is available. The State has a particular responsibility to ensure provision of appropriate services for detainees. It is essential for the individuals concerned, and the wider community, that high quality support and care is available to maximise mental health and wellbeing both during the period of detention and on return to everyday life. If this is not available then opportunities can be missed for diagnosing and offering treatment to detainees, which can reduce the chances of successful reintegration upon leaving the detention setting. These concerns are well documented by the Office of the Ombudsman in OPCAT annual reports.<sup>13</sup>
30. The Commission also has serious concerns about the prevalence of mental health issues amongst the prison population. Research undertaken by the Department of Corrections in 2016 found that 91% of prisoners had been diagnosed with a mental health or substance use condition during their lifetime and 62% had been diagnosed with at least one condition within the prior twelve months.<sup>14</sup> These results could be indicative of inadequate community based prevention and treatment services, resulting in people coming into potentially avoidable contact with the criminal justice system.

### *Legislative framework*

31. The Mental Health (Compulsory Assessment and Treatment) Act is complex and outdated. It is predicated on historical approaches to mental illness and fails to adequately recognise personal autonomy. The Protection of Personal and Property Rights Act is better, and is more consistent with a CRPD approach. But it too is deficient in its approach and complex in its administration.
32. Other relevant legislation includes the Intellectual Disability (Compulsory Care and Rehabilitation) Act, (Compulsory Assessment and Treatment) Act, the Substance Addiction (Compulsory Assessment and Treatment ) Act. There is a strong argument for reviewing the relevant laws and replacing them with a single universal framework that sets out clear, standard principles, is CRPD compliant and which supports personal autonomy to the maximum extent possible.

### *Holistic approaches.*

- 33. It is not possible to consider mental health and addiction in isolation from broader social concerns such as housing, standards of living, physical health, education, violence and abuse.**

These factors are all complex and interlinked, as are the responses and potential

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<sup>13</sup> For example, Monitoring Places of Detention: Annual Report of Activities under the Optional Protocol to the Convention Against Torture 2015/16 Report at p17-18 and 2014/15 report at p39,40.

<sup>14</sup> [http://www.corrections.govt.nz/resources/research\\_and\\_statistics/journal/volume\\_4\\_issue\\_2\\_december\\_2016/state\\_of\\_mind\\_mental\\_health\\_services\\_in\\_new\\_zealand\\_prisons.html](http://www.corrections.govt.nz/resources/research_and_statistics/journal/volume_4_issue_2_december_2016/state_of_mind_mental_health_services_in_new_zealand_prisons.html)

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solutions. Having a safe, healthy home, sufficient food and clothing, a job and enough money to live on are all baseline requirements for being physically and mentally healthy. Social connections, physical activity and meaningful engagement and relationships with others are also crucial to good mental health. Inability to access all or any of these basics of living will have a detrimental impact on wellbeing.

34. For this reason, approaches and responses to mental wellness must be cohesive and “joined up” and support holistic methods of addressing individual needs and determinants of good health. They must also recognise that disadvantage, harm and trauma can have lasting and sometimes intergenerational consequences. Attempting to “cure” or address issues after they have arisen is only part of the picture and should generally not be necessary if we get the building blocks of our community right. There must be a real, tangible commitment to making sure that New Zealand is a safe and good place to live for all people.

35. The United Nations Special Rapporteur has noted:

“Public policies continue to neglect the importance of the preconditions of poor mental health, such as violence, disempowerment, social exclusion and isolation and the breakdown of communities, systemic socioeconomic disadvantage and harmful conditions at work and in schools” Approaches to mental health that ignore the social, economic and cultural environment are not just failing people with disabilities, they are failing to promote the mental health of many others at different stages of their lives”<sup>15</sup>

36. Furthermore, it is important to ensure that systems and policies do not themselves create barriers for service users. Artificial distinctions and categories created by funders and services providers alienate service users and their families and can lead to people “falling between the gaps”. This can occur when there are insufficient linkages between social support agencies vis a vis “clinical” support services and also within services. For example, when a service user does not quite fit standard referral or acceptance criteria or has a “dual diagnosis” or AOD challenges that place them outside accepted treatment or support categories. Neither should there be structures or artificial silos that create unnecessary barriers for disabled people who also require access to mental health services. To be effective, services must be flexible and meet the needs of consumers. Not the other way around.

**37. Whanau and family involvement is also a key component of an holistic approach to mental wellness.**

Individuals do not exist in isolation and relationships with others, particularly family members, are crucial to mental wellbeing. Legislative frameworks, policies and processes should appropriately recognise the key role of family /whanau and ensure that input can be obtained and maximised.

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<sup>15</sup> United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health a/HRC/35/21 at 5.

## What would a good legislative and policy framework look like?

- a. All legislation and policy will be consistent with a human rights approach and explicitly reference, and be aligned to, relevant human rights principles and obligations.
- b. The legal framework would be simple and accessible and not categorised by way of disability, condition or illness. A universal regulatory approach, grounded in the concept of maximum personal autonomy, should replace the current fragmented and disparate legislation in this area.
- c. Ultimately, all types of coercive treatments should be phased out. This includes non-consensual pharmacological treatment and all forms of seclusion and restraint. In the interim, coercive treatment should be absolutely restricted to those situations where it is absolutely necessary and where all other options have been thoroughly explored. Coercive treatment should be subject to very strict oversight and review mechanisms and should never be used as a substitute for staff shortages, good practice or for reasons of convenience or efficiency.
- d. Approaches and funding should be aligned across core social sector agencies and service providers.
- e. Funding and service delivery should be flexible and support the individual needs of consumers, not arbitrary and constrained by artificial service or funding constructs.
- f. Approaches would be supported by high quality data, disaggregated by key characteristics, to ensure accurate, timely and effective tracking and monitoring of progress and outcomes.
- g. Particularly vulnerable groups such as ethnic minorities, prisoners, members of the rainbow community and refugees require targeted and appropriate approaches that meet their needs and address outcome disparities and disproportionate mortality and morbidity within their population groups.
- h. The legislative and policy framework will support Maori rangatiratanga and self determination in the development and delivery of service solutions and approaches.