Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Submission: Aotearoa New Zealand's Universal Periodic Review 2024

Submitted by the Mental Health Foundation of New Zealand

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United Nations Human Rights Office of the High Commissioner

Submission on Aotearoa New Zealand's Universal Period Review

Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tīhei mauri ora.

He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora Hinengaro.

Introduction

1. Thank you for the opportunity to provide a submission to Aotearoa New Zealand's 4th UN Universal Periodic Review. The Mental Health Foundation of New Zealand (MHF) is a charity (or civil society organisation) working towards creating a society free from discrimination, where all people enjoy positive mental health and wellbeing.

2. Our submission focuses on the rights that relate directly to mental health, describing the issues of concern and recommendations for what the government can do to improve the situation. Overall, the MHF believes that while positive steps have been taken across all rights relating to mental health, there remains much work to do. Our response supports the findings of the national monitor of mental health services Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission, backed up by anecdotal evidence provided to us by people with lived and living experience of the mental health system in Aotearoa New Zealand since 2019. These stories are shared with us through many channels, including our information service with

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approximately 20 percent of these enquiries relating to mental health service access. Where possible we have provided quotes and stories in full.

Theme: D26 Conditions of detention

122.99 Take immediate steps to combat solitary and solitary confinement in medical facilities applied to juveniles, persons with intellectual or psychosocial disabilities, pregnant women, and breastfeeding mothers in prison and in all health care institutions.

Comment

3. We note there have been positive steps towards the reduction of solitary confinement before and since 2019. Overall, however, there is much work to be done, particularly for Māori (the indigenous people of Aotearoa New Zealand). According to the Ministry of Health,[i] between July 2021 and June 2022, 9.9 percent of those using adult mental health services in Aotearoa experienced solitary confinement. The total number of people who experienced solitary confinement has decreased by 26.9 percent since 2009, however, the number of Māori who have experienced solitary confinement has increased by 47 percent over the same time period.

4. Between July 2021 and June 2022, Māori were 5.5 times more likely to be put into solitary confinement than non-Māori, and for longer periods of time on average. This is an increased rate for Māori compared to non-Māori, indicating inequity has worsened. Those aged between 20-29 were the most common age group to be put into solitary confinement, with males being twice as likely as females to experience solitary confinement overall. Those aged 19 and under also experience solitary confinement, with a total of 90 young people having 184 solitary confinement events during the year.

5. The MHF advocates for the end to solitary confinement practices within mental health services across Aotearoa New Zealand. The elimination of solitary confinement is possible and sustainable, even in urban centres with diverse populations, and results in better outcomes for all such as a reduction in the number of staff assaults and injuries.[ii] Te Toka Tumai Auckland significantly reduced its rates of solitary confinement in mental health and addiction services from 30 in 2019-2020 to eight in 2021.[iii]

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6. Other regions that have successfully reduced solitary confinement, and at times sustained no solitary confinement, include Waitematā, Whanganui, South Canterbury and West Coast.[iv] These regions, in reducing solitary confinement, have also seen a reduction in calls to crisis teams, use of restraints and sedating medications, and assaults against staff and tāngata whaiora within inpatient units.

7. Specifically, the MHF recommends:

   a) Prohibiting the use of seclusion practices in mental health units in the new mental health law. This prohibition needs to be supported by adequate resourcing of services and changes to delivery models and practice approaches, building on the decade-long Zero Seclusion project and success of services that have achieved no solitary confinement at times.

   b) In the interim, working with the Zero Seclusion project to revise the elimination target, perhaps including staged interim targets. These targets need to be clear and well publicised to practitioners, championed by leadership, and supported by comprehensive and consistent recording and reporting of data to track progress.

Lived experience

8. The following quote is from a person experiencing solitary confinement in a mental health services in 2022:

"Both seclusion events felt very long. I believe the long stretch, (many, many hours), was not necessary because I was calm within 5 minutes and this would have been obvious had they been observing me. Instead, they opted for a punitive, unnecessarily long incarceration time....I destroyed my cardboard bed pan both times and slipped the pieces under the door, hoping in vain for human contact. The bedpans were not replaced and no staff member so much as approached the window. I looked out the window several times. At no point was I able to see another human being, staff or otherwise. Eventually I gave up and tried to sleep because there was nothing to do. If you were trying to design a space to send somebody into madness, this would be it. To my knowledge, I was not checked on at all whilst in solitary confinement but I concede they may have done so whilst I

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was sleeping. I was calm enough to leave within 5 minutes, yet they left me to suffer for hours." (2022)

Theme: D51 Administration of justice & fair trial

122.67 Take action to ensure the provision of physical and mental health services for those in detention facilities, as well as to reduce overcrowding in prisons.

Comment

9. We understand the rates of mental disorder and substance use disorder among the New Zealand prison population are very high and climbing, with over 90 percent of this population having a lifetime diagnosis of a mental health or substance use disorder. A 2020 report by experts claimed the increase in the prison population has been met by little increase in prison capacity or funding for specialist mental health services in prisons.[v]

Theme: E41 Right to health – General

122.100 Progress with efforts in addressing disparities in mental health and improve services for vulnerable groups.

122.94 Enhance mental health policies with a view to guaranteeing that persons with mental health conditions and psychosocial disabilities have access to appropriate mental health services, including community-based care, which respect their dignity and human rights.

Theme: F4 Persons with disabilities

122.162 Respect the rights of persons with mental health conditions and psychosocial disabilities, in line with the Convention on the Rights of Persons with Disabilities, including by combating institutionalization, stigma, violence and overmedicalization, and by developing community-based and people-centred mental health services which promote inclusion in the community and respect their free and informed consent.

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Comment

10. Despite some increased investment and service access particularly in primary mental health, when New Zealanders need mental health or wellbeing support, they are often unable to access it.[vi] Māori, Pasifika and young people experience significant inequities of access.[vii] Wait times are long and growing.[viii] There are significant workforce gaps in a wide variety of services and supports.[ix]

11. When people do access supports, they lack genuine choice in them, including whether those supports are suited to their needs, located nearby, or aligned with their culture, worldview, human rights and preferences. There is minimal access to non-Western, non-biomedical interventions, such as kaupapa Māori (for Māori, by Māori) supports or peer-led options.[x]

12. The national monitor reports a recent reduction in access to specialist services. We have also heard anecdotally of people struggling to access secondary mental health services, of the lack of early intervention support available to prevent people from experiencing an acute crisis event, and of primary care and telehealth services increasingly providing support to people with high and complex needs.[xi] A 2017 examination[xii] of why the Australian system is failing to provide adequate care for people with schizophrenia and related disorders reflects some of the current barriers and solutions to supporting people with severe and complex mental health problems in Aotearoa New Zealand, such as increasing funding for the full spectrum of services, improved housing and employment options and continuity of care (and we would add culturally-responsive care).

13. There are some great examples of community-based care approaches, but these are not funded adequately or distributed consistently across the country. Some examples include:
    - Rapua Te Āhuru Mōwai: A kaupapa Māori mental health service pilot which provides affordable, high-quality rental housing to tāngata whaiora in Tāmaki Makaurau. It operates as a collaborative partnership between Te Toka Tumai clinical services, CORT (community housing provider) and Mahitahi Trust to provide wrap-

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around support to people who would otherwise have nowhere to go after being discharged from an inpatient mental health unit.
- Kōtukutuku Papakāinga in Ōtara, Auckland: This community housing accommodation is run by a community housing provider for those with living experience of mental distress. It is made up of 40 single-bed units, a whānau apartment for family members to visit, and a Whare Manaaki, a gathering place for hui and celebrations where tenants come together as whānau. Tenants are able to access wellbeing support services if they need or want them, and the papakāinga uses peer support. It is a home, a refuge, and a house of healing, and is grounded in kaupapa Māori.
- Whanganui Crisis Response Team: An initiative between Māori health provider Te Oranganui Trust, mental health charitable trust Balance Whanganui, the Police and the regional health service. It deploys seven-person crisis response teams including mental health and alcohol and drug clinicians, a family violence key worker, peer support worker and cultural support person, to help people experiencing mental health crises. This model seeks to respond to people with compassion and without police, unless necessary, and to reduce admissions to inpatient services.

14. The MHF received correspondence from two people with lived experience in 2023 and 2021 raising concerns about the imminent closure and lack of funding of community-based respite/support groups/community hubs for people with lived experience.

15. We also note findings from the national monitor that the use of Community Compulsory Treatment Orders (CCTOs) has increased over a five-year period. In 2017, 4,259 people were subject to CCTOs on an average day compared to the year from 1 July 2020 to 30 June 2021, where the average number of people under a CCTO was 4,608.[xiii] It's 2023 monitoring report also found there have been substantial increases in medication dispensing, particularly for young people, and this warrants investigation into whether young people have a full range of treatment options available.[xiv]

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16. The MHF:

a) Recommends the government understand the scope of mental health need, including how many people require support, current choice and access levels, service transitions and inequitable outcomes, and fund services commensurate to this need. This will need to include addressing critical data gaps in service access, experience and outcomes, and population prevalence.

b) Supports the recommendations of the latest monitoring report,[xv] including the need to address workforce shortages, increase funding of kaupapa Māori services (services for Māori, by Māori), expand services for young people, decrease the use of compulsory treatment and increase acute community services across all districts to address acute mental health need.

Lived experience

Lack of access to specialist services

"We are currently paying privately to see a psychiatrist but when I asked our GP if [my husband] could go under the public system (e.g. if it was cancer, he would be under a cancer specialist) but she said no the GP's manage the patient's care unless they become a crisis situation...But I was really shocked to hear that if we want to see a psychiatrist to review medications and improve his mental health, we have to pay privately at NZ$500/hour. We are fortunate to be able to 'afford' this but what do others do? I felt like I wasn't sure where to go. We tried the Health Improvement Practitioner's clinic [a primary mental health initiative] but my husband who was unstable at the time, got up and walked out. In my mind we need to work hard to reduce the stigma with mental health and also provide better support via GPs to psychiatrists for patients with a mental health diagnosis." (story provided in 2023)

"Late 2021 because of the funding restrictions (treatment only funded for 3 years) my son was referred to the community mental health team and discharged from [a specialist mental health team for psychosis]. This very quickly turned into a very stressful time and situation for myself and whānau...After my son rang the community mental health team to say he couldn't get to this first assessment appointment with

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the new psychologist he was discharged from the community mental health team. The psychologist from this team wrote in his report that he mustn't need help if he can hold down a job…My son barely holds down a part time job…No where else other than our general practitioner doctor for support for the future." (2021)

"For a parent of then nine year old child who in 2020 threaten to take his own life…the lack of any intervention by Child Adolescent Mental Health, following his assessment by their Crisis Team, disturbs me to this day….my child's distress was acute…The "ambulance" that my son required here in Wellington, wasn't merely parked at the bottom of the hill; it was parked up at Ninety Mile beach with its blinkers off! Is it any wonder, with services so stretched, that we here in New Zealand have one of the highest rates of youth suicide in the world. Children in acute distress need to be seen and treated by mental health professionals." (2020)

"My brother was escorted to the crisis team by the police. The crisis team asked him questions and even though he clearly stated he had nothing to live for, he was discharged after I said he could stay with us for one night. There has been no follow up, no welfare checks, and I've had to advocate for him to even access medication. There is still no plan in place for my brother, and I am not equipped to support him the way he needs. He runs out of medication next week, and if I wasn't here there's no way he'd reach out and ask for more help. He is no state to advocate for himself, and I worry about people who don't have any support."

Lack of access to services in rural setting

"I was unable to access any therapy at all through the public health system on the West Coast. I am having to go private and drive three and a half hours a week to do that once I leave the inpatient unit. The regional service has been trying to recruit someone like a psychologist for the area for five years. There is nothing that allows them to refer me to another area for me to take advantage of therapy. I won't be the only person in a rural area going through this." (2021)

Lack of early intervention support

"…I was not able to navigate the system well enough to avoid crisis point. My private referral to a psychiatrist led to a head scan, but no medication… By the time April rolled around, I had hit crisis point, been admitted to hospital under the CAT

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Act, had a 4 week stay and been discharged. The lack of community-based support is the reason I wound up in hospital. I look back on hospital as a place of boredom interspersed with trauma events. Having to go to hospital was a massive disruption to my life. I think the period leading up to my admission was the most critical to my wellbeing because it was a missed opportunity to catch the issue early. Our district inspectors are not interested in how inadequately the system serves people during this period because they are not yet under the Act." (2022)

Discrimination within services

"What disappoints me is that there was stigmatisation inside the psychiatric hospital. I was having an argument with a staff member and another staff member told her not to speak to me because I was mental. This happened inside a psychiatric hospital with psychiatric nurses."

Dignity and respect not upheld

"Once I was under the Mental Health Act I felt not respected - the police were called to take me to the hospital several times. I felt so bad and humiliated when the police came to the hotel where I was staying and in front of all the staff and visitors I was taken by the police, I lost all dignity and credibility."

Physical use of force to administer medication

"I was minding my own business doing a jigsaw when they approached and asked me to take some medication. At this point, they had asked once previously for me to take it and I had said no. The nurse said "we can do this the easy way or the hard way" but did not go into detail about what "the hard way" might mean. They then started trying to encircle me. I backed away with my hands raised defensively, however they lunged at me and forced me to the ground. They crushed my ribcage, and this made every breath whilst lying down to sleep painful for about a week afterward…While they were holding me down in prone position, I was struggling to get free. A male health-worker took my wrist and bent it backwards unnaturally far. This was extremely painful. He said "that doesn't feel very nice does it?" It was a tactical move designed to maximise pain whilst not leaving bruises. It is inconceivable to me that so little attempt was made to administer the medicine peacefully. They should use a variety of strategies and have at least 10 attempts before resorting to violence…" (2022)

122.30 Continue to work to fully harmonize national law with the provisions of the Convention on the Rights of Persons with Disabilities

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Comment

17. The MHF acknowledges the Government's commitment to repealing and replacing the Mental Health Act and recent publication of policy proposals that demonstrate a clear intention to develop a new mental health law that upholds human rights, including facilitating a supported decision-making regime, and supports te ao Māori (Māori world view) approaches to recovery. The MHF continues to encourage all political parties, and the next government, to commit to repealing and replacing the Mental Health Act to ensure continued progress across election cycles.

18. People who have been subjected to the Mental Health Act have told us progress on law change is slow – "*I hope laws will be set as soon as possible on this repeal and replacement of Act. Patients cannot wait for ten years when they are suffering being under the present Act.*"

122.157 Continue its efforts in implementing legislation and strategies to promote and protect the rights of children and young people and persons with disabilities

Comment

19. The current national strategy *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* provides a sound basis for a population approach to mental health. The MHF recommends a legal mandate for a mental health, addiction and wellbeing strategy to ensure the important work advanced in *Kia Manawanui Aotearoa* will continue to progress and provide transparent and robust accountability structures to continue long-term and tangible change.

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Thank you for the opportunity to comment.

Mauri tū, mauri ora,

Shaun Robinson
Chief Executive

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About the Mental Health Foundation

The MHF's vision is for a society where all people flourish. We take a holistic approach to mental health and wellbeing, promoting what we know makes and keeps people mentally well and flourishing, including the reduction of stigma and discrimination (particularly on the basis of mental-health status).

The MHF is committed to ensuring that Te Tiriti o Waitangi and its Articles are honoured, enacted, upheld and incorporated into our work, including through our Māori Development Strategy. We are proud that Sir Mason Durie is a Foundation patron.

The MHF takes a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities, create support and social inclusion for people experiencing distress, and develop positive mental health and wellbeing.

We value the expertise of tāngata whaiora/people with lived experience of mental distress and incorporate these perspectives into all the work we do.

Established in 1977, the MHF is a charitable trust, and our work is funded through donations, grants and contract income, including from government.

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