FACTSHEET – UPR 2018 – New Zealand
3rd CYCLE UNIVERSAL PERIODIC REVIEW

Mental health and human rights in New Zealand

Contact: Judi Clements, Independent Consultant, judimclements@gmail.com

SUMMARY OF KEY ISSUES FROM PREVIOUS UPR CYCLES

Over two UPR cycles, New Zealand (NZ) has not received recommendations specific to mental health.

UN bodies have recommended that NZ:

- ensure **no one is detained against their will** in any medical facility on the basis of actual or perceived disability (Committee on the Rights of Persons with Disabilities, 2015)[i] (CRPD), **note concern** that current law may lead to arbitrary detention of persons with mental illness (Working Group on Arbitrary Detention, 2015)[ii] (WGAD).
- ensure all mental health services are provided on the basis of **free and informed consent** (CRPD)
- amend mental health legislation to **comply with UNCRPD** (CRPD)
- revise laws to **replace substituted decision-making** with supported decision-making (CRPD).
- limit **seclusion** and prohibit its use for persons with disabilities (Committee against Torture, 2015)[iii] (CAT), **eliminate use of seclusion and restraints** in medical facilities. (CRPD), **note concern** at widespread seclusion within mental health services (WGAD).

NATIONAL FRAMEWORK

New Zealand ratified the UNCRPD in 2008, and has a legislative framework (including the Bill of Rights Act, Human Rights Act, and Code of Health and Disability Services Consumers' Rights) designed to protect the human rights of people who experience mental distress[iv].

However, the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) permits people to be subjected to compulsory treatment, including seclusion, restraint and substitute decision making.

CRPD has recognised that compulsory treatment and restrictive practices are inconsistent with the rights and freedoms described in UNCRPD[v]. Most respondents to a NZ review in 2017 considered the MHA inconsistent with human rights laws and principles[vi]. Local critics have included the Mental Health Commissioner[vii], Office of the Ombudsman[viii], Human Rights Commission[ix] and Independent Monitoring Mechanism of the UNCRPD[x]. NZ's government has not yet committed to any change in the law.

The Treaty of Waitangi, the founding document of NZ, commits to actively protect Māori health[xi]. Law requires the health sector to work towards eliminating entrenched health inequities between Māori and others[xii]. Yet, Māori are significantly more likely to be subject to compulsory treatment, and to experience seclusion[xiii]. These disparities have increased in recent years[xiv].

Since 2009, a range of policies and initiatives have sought to reduce the use of seclusion and restraint, and reduce disparities faced by Māori. Recently a goal has been set of eliminating seclusion by 2020[xv]. Progress is slow, and has stalled in recent years.

CHALLENGES	IMPACT
High and growing rates of compulsory assessment and treatment • **10,000 people** are subject to the MHA each year • **102 people per 100,000** are receiving compulsory treatment at any time • **Māori are 3.4-3.6 times more likely** to be subject to compulsory treatment. Inequity increased in recent years • Rates **vary significantly by region**[xvi] • Rates **increased 25%** between 2005 and 2016, and are high by international comparison[xvii,xviii].	Compulsory treatment removes individuals' rights to decide (with or without their chosen support) at the time or in advance, on their own treatment. It permits detention, and administration of treatments including electro-convulsive therapy without informed consent. It can restrict an individual's freedom of movement, and ability to make broader decisions about their life. Compulsory treatment is incompatible with UNCRPD, particularly article 12, equal recognition before the law, and article 14, liberty and security of the person. The MHA allows for indefinite compulsory treatment. Some community treatment orders may have been in place for more than 20 years. There is no independent review or monitoring of the MHA, and no clear records exist of long-term use of Community Treatment Orders.
Use of seclusion and restrictive practices in mental health services • **11%** of people admitted to inpatient services experienced seclusion in 2016 • Use of **physical, environmental and chemical restraint** is widespread within services • **Māori are 4.8 times more likely** to experience seclusion in adult services. Inequity has increased in recent years • The use of seclusion **varies significantly by region** • Rates **decreased 25% since 2009**, but have **stopped decreasing** recently[xix]	Seclusion is the practice of placing a person alone in a room or area from which they cannot exit freely. It provides no therapeutic benefit, isolates people in distress at times when they are most in need of support and contact. It poses risks including re-traumatisation, loss of dignity, significant distress, and even death[xx]. Seclusion, restraint and restrictive practices limit individuals' freedom of movement. Seclusion is incompatible with article 14 of the UNCRPD. CAT, CRPD and the Special Rapporteur on Torture have recommended its elimination in health services. Since 2009, a range of policies andinitiatives have sought to reduce the use of seclusion and restraint in mental health services, and reduce disparities between Māori and others. Progress is slow, vigilance is needed to ensure that a reduction in seclusion does not lead to an increase in other restrictive practices.
Denial of legal capacity to make decisions, and lack of supported decision making approaches	A person subject to compulsory treatment under the MHA is denied legal capacity, even though an estimated 66% of people under the MHA would have the capacity to consent to treatment[xxi]. Choices about their treatment are made through substitute decision making. This denies autonomy and control, and is inconsistent with article 12 of UNCRPD. Individuals may need support to exercise their decision making. Some may benefit from advanced directives that describe how they would like decisions to be made. Supported

	decision making approaches would be respectful of human rights.
Māori experience higher rates of compulsory treatment and restrictive practices	Māori are significantly more likely than non-Māori to be subject to compulsory treatment and seclusion[xxii]. These disparities have increased in recent years[xxiii]. Institutional racism, cultural competence among healthcare workers, and the legacy of colonisation have been identified as significant in the way mental health services assess, respond to and treat Māori[xxiv]. Detention can limit access to whenua (land), whānau (family) and te ao Māori (culture, or the Māori world), all of which are critical to recovery and wellbeing for Māori.
Widespread discrimination against people who experience distress	Stigma and discrimination associated with mental distress persist within NZ. Media coverage is often prejudicial, and public attitudes – while improving – are often judgemental[xxv]. People who experience mental distress have shorter lives and worse physical health[xxvi], are less likely to be employed[xxvii], and are more likely to experience homelessness[xxviii] and social isolation[xxix].

RECOMMENDATIONS
That the New Zealand Government: 1. acknowledges in 2019 that the MH(CA&T) Act does not comply with human rights and repeals before the next UPR 2. develops a new legal framework within the next five years which ensures that all mental health services are based on free and informed consent, outlaws compulsion, seclusion and other coercive practices, includes supported decision making, independent advocacy and fully complies with UNCRPD 3. establishes within 2019 independent monitoring to ensure vigilance in eliminating all forms of restrictive practice 4. extends and funds national and community-based programmes to challenge discrimination and promote citizenship, and establishes annual monitoring and measuring of agreed social inclusion indicators by 2021 5. ensures that all frameworks, programmes and indicators are developed with/by Māori and people with experience of mental distress

References/sources:

[i] United Nations. (2014). *Committee on the Rights of Persons with Disabilities – Concluding observations on the initial report of New Zealand.* Retrieved from : https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fNZL%2fCO%2f1&Lang=en

[ii] United Nations. (2015b). *Report of the Working Group on Arbitrary Detention – Mission to New Zealand.* Retrieved from: https://www.ohchr.org/en/hrbodies/hrc/regularsessions/session30/documents/a_hrc_30_36_add_2_eng.docx

[iii] United Nations. (2015a). *Committee against Torture – Concluding observations on the sixth periodic report of New Zealand.* Retrieved from: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G15/110/91/PDF/G1511091.pdf?OpenElement

[iv] Soosay, I., & Kydd, R. (2016). Mental health law in New Zealand. *BJPsych International, 13*(2), 43-45.

[vv] United Nations (2014), as above.

[vi] Ministry of Health. (2017a). *Submissions on the Mental Health Act and Human Rights discussion document – An analysis.* Retrieved from: https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment

[vii] Health and Disability Commission. (2018). *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner.* Retrieved from: https://www.hdc.org.nz/media/4688/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf

[viii] Office of the Ombudsman. (2017). *The Mental Health Act and Human Rights - Submission from the Office of the Ombudsman.* Wellington, New Zealand : Office of the Ombudsman.

[ix] Human Rights Commission. (2017). *Submission regarding the Ministry of Health's discussion document 'The Mental Health Act and human rights'*. Retrieved from: https://www.hrc.co.nz/index.php/download_file/view/3662/519/

[x] Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities. (2014). *Making disability rights real - Whakatūturu ngā tika hauātanga. Second Report of the Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities. Aotearoa | New Zealand July 2012 – December 2013.* Retrieved from: https://www.hrc.co.nz/files/8014/2357/0686/Making-disability-rights-real-full-report.pdf

[xi] Kingi, T. K. R. (2006). *The Treaty of Waitangi and Māori Health.* Retrieved from: https://www.massey.ac.nz/massey/fms/Te%20Mata%20O%20Te%20Tau/Publications%20-%20Te%20Kani/T%20Kingi%20Treaty_of_Waitangi_Maori_Health1.pdf?95BAA6D4A43BA51CFFB9589A7660869D

[xii] Came, H., Cornes, R., & McCreanor, T. (2018). Treaty of Waitangi in New Zealand public health strategies and plans 2006–2016. *The New Zealand Medical Journal, 131*(1469), 32-37.

[xiii] Ministry of Health (2017b), as above.

[xiv] Health and Disability Commission (2018), as above.

[xv] Health, Quality and Safety Commission. (2018). *Zero seclusion: towards eliminating seclusion by 2020.* Retrieved from: https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/Resources/Zero_seclusion_infographic_Mar_2018.pdf

[xvi] Ministry of Health (2017b), as above.

[xvii] O'Brien, A. J. (2014). Community treatment orders in New Zealand: regional variability and international comparisons. *Australasian Psychiatry, 22*(4), 352-356.

[xviii] Gordon, S., & O'Brien, A. (2014). New Zealand's mental health legislation needs reform to avoid discrimination. *New Zealand Medical Journal, 127*(1403), 55-65.

[xix] Health and Disability Commission (2018), as above.

[xx] Mental Health Foundation of New Zealand. (2016). *Legal coercion fact sheets.* Retrieved from: https://www.mentalhealth.org.nz/assets/Our-Work/MHF-Legal-Coercion-Fact-Sheets-2016.pdf

[xxi] Skipworth, J. (2013) in J Dawson, K Gledhill (Eds.) *New Zealand's Mental Health Act in Practice.*

[xxii] Ministry of Health (2017b), as above.

[xxiii] Health and Disability Commission (2018), as above.

[xxiv] Mental Health Foundation of New Zealand (2016), as above.

[xxv] Deverick, Z., Russell, L., & Hudson, S. (2017). *Attitudes of adults towards people with experience of mental distress: Results from the 2015 New Zealand Mental Health Monitor.* Retrieved from Health Promotion Agency: https://www.hpa.org.nz/sites/default/files/717221_6%20LMLM%20Report%20MHS%202015%205%20July.pdf

[xxvi] Te Pou o te Whakaaro Nui. (2017). *The physical health of people with mental health conditions and/or addiction. Evidence update: December 2017.* Retrieved from: https://www.tepou.co.nz/uploads/files/TePou-EquallyWell-EvidenceReview-FullReport.pdf

[xxvii] Gordon, S., &., Peterson, D. (2015). *What works: Positive experiences in open employment of mental health service users.* Retrieved from Mental Health Foundation of New Zealand: https://www.mentalhealth.org.nz/assets/ResourceFinder/What-Works-web-2015.pdf

[xxviii] Parliamentary Library. (2014). *Homelessness in New Zealand.* Retrieved from: https://www.parliament.nz/en/pb/research-papers/document/00PLEcoRP14021/homelessness-in-new-zealand

[xxix] Gordon, S., Davey, S., Waa, A., Tiatia, R., & Waaka, T. (2017). *Social Inclusion and Exclusion, Stigma and Discrimination, and the experience of mental distress: Aotearoa/New Zealand.* Retrieved from Auckland, New Zealand: Mental Health Foundation of New Zealand : https://www.mentalhealth.org.nz/assets/Our-Work/Social-Inclusion-and-Exclusion.pdf