Submission to
The Commission of Inquiry
into Mental Health and Addictions
from

10 June 2018

Understand "I am human".

Tangata whaiora (anonymous)
Commenting on the topic "Helping people to deal with mental health challenges early"
Balance Aotearoa Forum, 17 May 2018

"To be banished from humanity – seen as unworthy of belonging and confined in seclusion– is deeply damaging to the human soul. Forced treatment – including forced medication and forced electro convulsive treatment, as well as forced institutionalisation and segregation – should no longer be practiced. Instead, States should ensure that people with mental health conditions and those with psychosocial disabilities can access treatment and support services, including peer support, in their communities. Segregation is harmful – not only for the individual, but also for the community as a whole."

Zeid Ra'ad Al Hussein, UN High Commissioner for Human Rights, 14 May 2018[i]

Mihimihi

Ka tangi te Pipiwharauroa Kui Kui Whiti Whitiora
Te Karanga a te Runga Rawa he Aroha ranei tou
Nana I homai taana ko te Tama o te Rangimarie
Te Whetumarama o te Ata
Tona Mangai kupu mai
No reira Ka mihinuirawa ki te Kaihanga
Nga mihi ano hoki kia Koutou katoa.

Otira tena tatou katoa e tu nei. Kiahari te hamama kia Ihoa onga mano, kei te wehi kia ia te timatatanga o te whakaaronui. Nana nei I hanga nga mea katoa ki tou te rangi me te whenua me nga waahi ra hei whakaoranga ai, na kia whakapainga whakakororia whakahonore tona ingoa tapu I nga wa katoa. Kaati mo tena wahanga.

There is a great spirit of life that created all things in the universe as we know it which provided eternal laws for the control of every phase of life throughout the boundless universe and inclusive of our earthly manifestations. That supreme power is referred to in Balance Aotearoa NZ - (Korimana) as the Matua Runga Rawa Father of all. We each have a portion of that power and breathe its life giving sustenance throughout our earthly walk. Service is the coin of the spirit and there is no higher religion than service.

Naaku noa,
Balance Aotearoa

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Feedback from Whanganui forum for tangata whaiora

Balance Aotearoa held a forum for tangata whaiora on 17 May 2018 specifically to seek their views on potential improvements to the mental health and addictions system that we could recommend to the Inquiry, using questions supplied by the Inquiry. Key themes identifed were used to create the word cloud on page 5, and are summarised below:

- **Enable people to avoid becoming addicted to something that causes harm**

  There were concurrent themes here, one referring to prescribed medications and illicit drugs, and the other to community education about harm minimisation.
- **Prevent people from taking their own lives**

  The most prevalent theme here was encouraging people to talk about their struggles, followed by increasing choice of treatments, availibility of services when in crisis – including phone support lines, affirming people's worth and strengths, not treating overdoses as "non-serious" suicide attempts – responding with more support, and reducing financial pressure.
- **Build positive wellbeing for New Zealanders**

  A variety of themes that often focused on the culture of relationships i.e. people being more respectful, accepting , caring, and helpful. Also lifespan-focused wellbeing starting in childhood and continuing throughout life; better work/life balance and prosperity; person-centred support that is more responsive and helpful and less punitive and controlling; feeling supported to improve wellbeing.
- **Improve the quality of the support and interventions given to those who need it.**

  The main theme here was a holistic approach to wellbeing; access to support workers and advocates via primary care; more access to peer-run services; more focus on community-based services; consistency of care by clinicians; access to respite services; trauma-informed approach to care; emotional support.

- **Make it easier to identify when someone is facing mental health and addiction challenges & get them help more quickly**

  Prevalent themes were the need for ready access to adequate emergency housing or respite services; more focus on listening; more education about addictions, violence prevention, mental wellbeing, stigma, and discrimination; abuse prevention programmes; social situation, life history, and whakapapa being taken into account; different needs for addiction and mental distress; trauma-informed care; advocates who are able to refer to a psychiatrist.
  - **Help people to deal with mental health challenges early**

    Two highly prevalent themes were that everyone needs to be skilled at first-aid for mental distress and able to navigate services; and that peer support should be available via primary care, educational, and social/public service agencies. Also frequently mentioned were self-awareness and anti-stigma education; prevention/early intervention; avoiding the word "mental" as it is used as an insult (i.e. "You're mental!") , social connectedness, family-inclusive approaches, and more information on medications.
  - **Other issues**

    Free GP visits and prescriptions; need for clinicians to listen; medication alone is an insufficient response; GPs need recovery education; DHBs made more accountable for service quality; medication risks better notified; prescription information up-to-date across the system; services need to be more disability-friendly.

An integrated view
Balance Aotearoa believes the themes identified from our forum support and integrate well with the following recommendations, brought together from our wider peer networks . We believe these recomendations will improve the future wellbeing of all New Zealanders.

Uphold human rights
The New Zealand Government has obligations under a number of United Nations (UN) human rights instruments to ensure its citizens' human rights are upheld.[ii] Any and all actions following the results of this Inquiry into New Zealand's mental health and addictions services must meet these international obligations.

In particular, New Zealand's signing of the UN Convention of the Rights of Persons with Disabilities (UNCRPD)[iii] and accession to the Optional Protocol of that Convention[iv] (OPCRPD) mean these obligations must be implimented fully and without delay.

New Zealand now has a unique opportunity to lead the world by responding to the call from the UN High Commissioner for Human Rights quoted on the opening page of this submission. We can and should take immediate steps to end the human rights violations being committed against people who experience mental distress and addictions in New Zealand. Evidence from some of New Zealand's leading mental health professionals[v] supports such action.

Recognise and fully resource the rights of disabled people[1] to exercise leadership
The UNCRPD and OPCRPD provide the framework for understanding how the human rights of people with psychosocial disabilities need to be upheld. In particular, they outline the essential role of Disabled Persons' Organisations (DPOs) such as Balance Aotearoa in providing leadership.

In the past, examples of "consumer" leadership by people who experience mental distress and addictions have generated useful and widely-supported guidance, including published documents. However, such guidance has not been accorded the level of influence that was expected and desired by those who contributed to, and supported it. For example, in 2004, Our Lives in 2014[vi] articulated a vision for how future mental health services ought to be. Many of those aims have not yet been met, and are now being reiterated as part of the Inquiry process.

Future leadership by disabled people needs to be on an equal basis, and supported by democratic structures and processes that provde a clear mandate. DPOs need to have direct input to decision-making by government that affects the populations of people they represent. This view has been emphasised in the Conference of States Parties discussion at the UN on 12 to 14 June 2018[vii].

DPOs need to be independent of government influence. At the same time, DPOs must be sufficiently resourced to engage with disabled people and provide genuine representation of

[1] The UNCRPD is based on the Social Model of disability, which includes mental distress because of the way society fails to accommodate the needs of people experiencing mental distress. It can be argued that people with addiction issues are not accommodated by society in a similar way.

their views on issues as diverse as human rights and arbitrary detention, urban design, public transport, access to arts and education, and involuntary sterilisation, to name but a few.

Balance Aotearoa asks that the government provide the resources to establish adequate systems and structures for DPOs to be fully effective in this role. In particular, Balance Aotearoa is in a unique position to be a conduit for the views of people who experience mental distress, in the change process that will follow this Inquiry. We look forward to co-designing those changes in partnership with government agencies, led by the views of the people those services will be designed for.

Make change across-government

We ask the government to invest in children's wellbeing from the start of life, and ensure they are protected from deprivation by having adequate family income, good quality affordable housing, the ability to access health services and educational opportunities, and increased social engagement.

This systemic level of change will require cross-party accord that spans the political cycle and ensures that the wellbeing of New Zealanders is always the political priority. Increased wellbeing from the start of life and connection to a thriving community will inevitably improve mental wellbeing.

We do not agree with everything the government's former chief science adviser Professor Sir Peter Gluckman wrote in his 2017 report "Rethinking New Zealand's Approach to Mental Health and Mental Disorder: a whole-of-government, whole-of-nation long-term commitment"[viii]. However, we do support the statement that:

"We need to build a holistic, people-centred resource and service. We cannot focus only on treatment... ...The rethink/revitalisation will need to involve not just the Ministry of Health but also the Ministries of Social Development, Education, Oranga Tamariki, Social Housing, and the Police, Ministry of Justice, and Department of Corrections, among other agencies. It will involve not just government but also the complete range of relevant resources across the community: iwi, non-government organisations, volunteers, churches, community groups, etc."[ix]

Recognise that "The evidence base for psychiatry remains thin"[x]

The entire mental health system in New Zealand is premised on the presupposition that psychiatric theory is valid, and psychiatry is the best means of supporting people who experience mental distress to recover and live well.

However, the evidence for this presupposition is weak. Many studies of the efficacy of psychiatric drugs show that they are no more effective than placebo and have serious detrimental health effects.[xi] The poor outcomes often experienced by people who are exposed to psychiatric analysis and treatment suggest that alternatives, including no treatment, should be considered equally as valid and effective as some psychiatric treatments on a population basis.

People are being forced to undergo treatments that are known to present significant risks of harm, according to diagnostic criteria the validity of which are poorly supported by scientific evidence, when some of those treatments are commonly no more effective than placebo. Such an imposition is clearly unethical and a violation of human rights.

We accept that psychiatric treatment does benefit some people. However, psychiatric hegemony must be reduced, and forced treatment must be stopped.

Review and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992[xii]
Balance Aotearoa has proactively laid the groundwork to enable a review of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) by insisting that the New Zealand Disability Action Plan 2014-2018 included Action 9d.

"Explore how the Mental Health (Compulsory Assessment and Treatment) Act 1992 relates to the New Zealand Bill of Rights Act 1990 and the CRPD*."*[xiii]

The resulting report from the Office of the Director of Mental Health and Addictions Services (ODMHAS)is yet to be published outside its release to the Inquiry. However, it clearly shows there is a widespread view that the MHA contravenes the Bill of Rights Act (BORA) and the UNCRPD in a number of ways.

For example, in Article 12 of the UNCRPD, States Parties including New Zealand reaffirmed that disabled people have the right to be treated equally before the law, to enjoy legal capacity on an equal basis with others, and to be adequately supported to exercise that legal capacity. The MHA does not recognise legal capacity, and since people are subject to the MHA solely on the basis of their perceived disability, those disabled people are not accorded the same rights as others on an equal basis.

We urge the government to immediately review and replace the MHA with legislation that recognises legal capacity, and prohibits forced treatment and detention of people experiencing mental distress. Any replacement legislation needs to require that people are able to choose.

Balance Aotearoa does some work with people who have addiction issues, and is aware that similar concerns exist with regard to the Substance Addiction (Compulsory Assessment and Treatment) Act 2017[xiv]. However, we have not explored this issue.

Ensure that supported decision-making replaces substituted decision-making
Our collaborative work with ODMHAS has shown that there is also widespread support for review of the informed consent and second opinion processes under Section 59 of the MHA.

There are solutions available that can reduce or eliminate substituted decision-making without waiting for changes to the MHA to be completed. Dr. Pat Deegan for example provides a useful analysis and set of tools for supported decision-making in psychiatry[xv]

A useful literature review commissioned by Office for Disability issues (ODI) is available to inform this work.[xvi]

We urge the government to act switfly to ensure that the legal and legislative questions that remain are resolved without delay, and eliminate substituted decison-making.

Increase access to advocacy support immediately

The UN High Commissioner for Human Rights has made it clear that coercion and forced treatment no longer have a place in mental health services[i]. Until the necessary reforms are made there is an immediate need for increased access to advocacy support when people are in acute services or have their rights to choose removed under the MHA.[2]

In the current circumstances the views and preferences of people experiencing mental distress are not sufficiently taken into account by clinicians and by Mental Health Tribunals (MHTs). People often place their trust the MHT process to genuinely listen and to protect them from being forced to accept treatment or control they are unwilling to endure.

People also attempt to resolve issues by contacting District Inspectors (DIs), the Health and Disability Commission's Advocacy Service (HDCAS); or the Human Rights Commission (HRC)

Common complaints[3] from people who have appealed to the MHT, DI, HDCAS or HRC processes for their preferences and views to be implemented are:

1. that their appointed lawyers and/or DIs are"just clipping the ticket" (i.e. not providing robust advocacy but fulfilling their role minimally in order to get paid)
2. that even if they have a convincing argument and sufficient advocacy, the MHT members default to accepting the views of clinicians anyway.
3. HDCAS Advocates are not able to directly advocate for the person they are supporting. Many people who access this service find this limitation frustrating and unhelpful, as the most critical support they require is in maintaining the courage and presence of mind required to ensure their issues are resolved to their satisfaction.
4. The HRC process is similarly unhelpful for many people because of the time it takes to get responses, arrange meetings etc, and the often-unequal representation of parties in the meetings when they occur. People also complain that the focus in these meetings is on compromise to reach agreement, rather than on robust defence of the person's rights.

When their views are listened to but discounted in favour of the privileged views of clinicians or service providers, people may lose all faith in the system. As a result they either become more unwilling to accept treatment and escalate the assertion of their human rights, or lose hope altogether and become compliant. Alternatively they may passively resist by simply going along with the requirements until they are released. Anecdotally, these passive approaches are sometimes associated with later suicide because the person cannot endure another experience of such violation and sees no other hope to escape their distress.

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2 See also the section on advocacy under "Improve the performance of privacy protection and complaints processes" pp. 11-12

[3] These complaints do not necessarily represent the view of Balance Aotearoa.

Those who resist often resort to a combative approach that is met with punitive sanctions such as the use of seclusion or restraint, and/or a "chemical strait-jacket" – being medicated to the point they cannot function to resist.

MHTs, DIs, HDC and HRC should protect the human rights of people using mental health and addiction services to the maximum extent possible, and default to that protection having priority. The views of clinicians must be fairly taken into account alongside those of service users and their family and whānau (if their involvement is supported by the service user). However, clinicians' views should not be upheld at the cost of violating a person's human rights unless there is a compelling reason to do so that is supported by clear evidence and not merely an opinion.

Advocacy support needs to be focused on supporting the individual to self-advocate wherever possible, but also be able to advocate on behalf of the person if asked to do so. Advocacy and robust upholding of rights should not be subverted by organisational or personal performance-related concerns such as resolution targets or time-limits.

Eliminate forced treament and seculsion

If it were not sanctioned under the MHA, enforcement of the opinions of an individual or group of people over another individual against their will would meet the definition of torture or cruel, inhuman, or degrading treatment or punishment under the UN Convention Against Torture (CAT)[xvii]. Where such enforcement is done unlawfully, it does constitute torture or cruel, inhuman, or degrading treatment or punishment.

Balance Aotearoa is actively working with District Health Boards (DHBs) and the Health Quality and Safety Commission (HQSC) Mental Health and Addictions Quality Improvement Programme to eliminate the use of seclusion by 2020.

Adopt a wellbeing approach

We support The Wellbeing Manifesto[xviii], created by Mary O'Hagan and her team at PeerZone from information gathered at the Peer-Led Paradigm Shift seminar held at Otago University of Wellington on 22 November 2017. In particular we support its call for a systemic change of focus from Big Psychiatry to Big Community, as a means of improving wellbeing and reducing the incidence and the impact of severe mental distress.

Current services tend to focus on symptom control/elimination, rather than on supporting people to identify and manage the causes of their distress and what they believe would be most helpful to them.

There needs to be a range of services and supports that people can access so that the help available is not limited to psychiatric diagnosis and treatment. Service users often find that seeking help makes their situation feel more hopeless when they are declined service because they are not deemed to be an immediate risk to themselves or others. Some find this experience so humiliating and degrading that they are unwilling to try again.

Services need to emphasise support and problem-solving before seeking to diagnose people with an illness, or assessing their risk profile as an entry criterion to receiving service. The result of seeking help should never be a decline without any other options offered.

Significant changes are being made in Whanganui, with a network and hub model of service delivery. This model aims to provide more integrated care without people being declined and sent back and forth between services.

Ensure potential non-psychiatric causes of symptoms are screened for and treated.
Many symptoms can have causes that are not addressed by psychiatric medications. People seeking, or referred for treatment are commonly medicated without being fully tested for potential alternative causes and non-medicalised solutions.

So-called mania and psychosis for example can be caused by lack of sleep, and are often treated with psychiatric medications[xix], yet it is recognised that many effects of sleep deprivation including psychosis can be resolved by sleep alone[xx]. Other potential causes of symptoms include:

- dehydration
- vitamin deficiencies
- any adverse drug event including use of cannabis, street or prescription drugs, alcohol
- exposure to other environmental toxins
- the normal sequelae of a “legion”[xxi] of diseases called "medical mimics".

Use person-centred, family and whānau-inclusive approaches
We recommend that the Open Dialogue[xxii] approach be introduced in New Zealand, including Peer-Supported Open Dialogue[xxiii]. We believe that this approach has the potential to directly address almost every issue raised by tangata whaiora at our Whanganui Forum.

In a study by Seikkula et al, two-year follow-up outcomes for Open Dialogue (OpD) versus Treatment as Usual (TAU) showed 82% of people had mild or no symptoms (TAU 50%); relapse at 24% with 74% of people returned to work or study (TAU relapse 71%); people on Disability Living Allowance (DLA) 23% (TAU 57%); Neuroleptic usage 35% (TAU 100%) and reduced hopsital admission rates.[xv]

The core principles of Open Dialogue are included in the appendix to this document.

Integrate health services
Disabled people who experience mental distress or addiction, and also have an impairment or support needs that are unrelated to mental distress, commonly find themeselves caught between two sets of criteria, and unable to access adequate support for one or the other of their needs.

The Equally Well initiative[xxiv] has provided some excellent information and instigated change from a mental health service-user perspective. This is encouraging but remains situated within a paradigm that considers mental health as separate from other aspects of health.

Mental health funding has been "ring-fenced' for many years, to ensure that the necessary improvements recommended by the Mason Report were brought into being. The ring-fence was intended to ensure that as deinstitutionalisation took place, people were not left without adequate support.

Balance Aotearoa acknowledges the security that ring-fencing of mental health funding has brought to services supporting people who experience mental distress. However, we consider that if there is to be a paradigm shift that focuses on ensuring wellbeing and supporting people in distress, through changes that occur across-government and have an holistic approach, this concept will need to be revisited.

Invest in childhood wellbeing

*"*Take care of our children. Take care of what they hear, take care of what they see, take care of what they feel. For how the children grow, so will be the shape of Aotearoa" – Dame Whina Cooper [1895 – 1994]

There is strong evidence that the first 1000 days of a child's life are an opportunity to improve their whole future,[xxv] and the transition to adolsecence can have a similar impact.[xxvi]

In 2009 the OECD made the following suggestions for New Zealand to improve how we care for our children as a nation.[xxvii]

- Invest early in children's lives;
- Concentrate on improving the lot of vulnerable children;
- Design interventions for children that reinforce positive development across their life cycle and across a range of well-being outcomes;
- Regularly collect high-quality information on children's well-being that is nationally and internationally comparable; and finally,
- Continuously experiment with policies and programmes for children, rigorously evaluating them to see whether they enhance child well-being, and reallocating money from programmes that don't work to those that do.

We acknowledge that change is occurring, in particular with the establishment of Oranga Tamariki. However, certain provisions of the Oranga Tamariki Act still hold the potential for profound violations of human rights, and the resultant trauma children experience in their formative years risks repeating the mistakes of the past.

We support the Children's Commissioner's calls[xxviii] for significant culture change across the system, to consider the needs of tamariki and rangatahi Māori through a Māori lens, and to avoid the weakening of commitment to transformational change by the use of qualifiers such as "where practicable" in legislation and policy.

Address inequalities for Māori and Pasifika peoples

The inequalities in economic, educational, social, justice, and health outcomes for Māori and Pasifika peoples remain a key underlying cause of the disparity in the prevalence of mental

distress and poor treatment outcomes for these populations. The relevant statistics are long-standing, relatively unchanging, and have been reported again and again.[xxix xxx xxxi xxxii xxxiii xxxiv]

We believe a human rights approach to understanding and resolving theses issues as part of a wide-ranging redesign of health, social, and economic systems will prove more effective than has been the case until now. By addressing systemic inequity, inequalities can be reduced.

Regarding mental health and addicitons services in particular, we recommend that a holisitic view, founded upon the principles of Te Tiriti O Waitangi[xxxv] is essential. Changing one aspect of the system without reference to the whole of a person's experience as a citizen will not work for people whose culture is holisitic, collective, and through-time oriented. We support the integrative approach described in Whāia Te Ao Mārama – the Maori Disability Action Plan, [xxxvi] and collaborative approaches such as that described in Collaborative and Indigenous Mental Health Therapy: Tātaihono – Stories of Maori Healing and Psychiatry.[xxxvii]

Partnership is essential. Genuine, ongoing engagement with people directly affected by the proposed changes must start at the very beginning. Balance Aotearoa is committed to working with government as a Disabled Persons' Organisation (DPO) that operates in partnership with Māori. Developing stronger relationships with Iwi, hapu, and whanau is an important part of our future development. We hope to increase that engagement as we strengthen our networks through our involvement in systemic change in the years to come.

The changes needed to overcome the multi-generation effects of inequality will take time. Immediately introducing more effective, family and whānau inclusive approaches such as Open Dialogue will provide much needed hope and evidence that change is happening.

Make trauma a public health issue

Treating the effects of trauma would have a significant effect upon the future use of mental health services[xxxviii xxxix xl]. Whilst the ACC sensitive claim process is helpful to those able to access it, its focus upon sexual trauma is too narrow, and many are denied access.

We need health services that can provide care in ways least likely to retraumatise, and full and ready access to treatment for trauma, for people with the least ability to pay for it. There are already some excellent resources available to educate service staff how to work in trauma-informed way. [xli]

Trauma is a particularly significant issue for Canterbury in the aftermath of the 2010 and 2011 earthquakes. A whole generation of children, and their parents and other adults living in the area at that time, have been subjected to ongoing stress and trauma for many years, and this needs to be specifically recognised and addressed as a public health issue. The same is true for Kaikoura following the earthquakes of 2016.

Nationally, the same can be said for Māori. The high mortality and rates and socio-economic inequalities experienced by Māori are in part the intergenerational effects of trauma caused by the colonisation of Aotearoa, and the subsequent ongoing subjugation of Māori through legislation, and through economic and social deprivation; inadequate or culturally inappropriate health care, social services, and education; and systemic prejudice in the justice system.

These injustices need to be addressed as human rights issues under the United Nations Declaration on the Rights of Indgenous Peoples (UNDRIP), and the International Covenant on Economic, Social and Cultural Rights (ICESC).

Interpersonal violence as sexual abuse, especially in domestic situations, is considered to be the mlost damaging source of trauma, particularly where it invovles a betrayal of trust from a person beleived to be in a caring or protective role. New Zealand's high prevalance of domestic abuse and interpersonal violence makes trauma a critical issue for public health.

Currently services often focus on "what's wrong with you" rather than "what happened to you?". The focus needs to be shifted away from pathologising according to percieved symptoms, and toward looking at the social and personal origins of, and solutions to, what people are experiencing.

Target Zero (zero suicides)

To our national shame, New Zealand has the highest youth suicide rate[4] in the OECD.[xlii] We support the call from Mike King and the Key to Life Trust[xliii] for the government to set a target of zero suicides. Anything less sends a message that New Zealanders are prepared to accept a number of suicides each year.

This high-level target could act as a focal point that drives change with the purpose of making people's lives better, so that suicide no longer seems the best option for anyone. Collective responsibility for achieving this target could be promoted as an opportunity for every New Zealander to play a part in turning around New Zealand's appalling leadership of international suicide statistics, rather than relying on clinical services to intervene only when a crisis has occurred.

We recommend that the government support and resource peer-led suicide-prevention initiatives like the Key to Life Trust as part of a wider increase in peer-led services.

Increase the peer workforce

Balance Aotearoa has been a visionary leader in introducing and promoting the value of mental health peer support in New Zealand. We believe that further increase in peer workforce numbers across the spectrum is an essential part of improving outcomes. Davidson et al provide a useful review of the evidence for the effectiveness of peer support in mental health.[xliv]

Clinical detachment and the assumption of superior knowledge has often been the cause of failure to connect with service users. The most effective clinician-patient relationships exist where ethical self-awareness and self-care is skillfully balanced with seeking to understand the patient's worldview, a degree of self-revelation, and where direct, honest, and respectful communication is a constant feature. These are also the hallmarks of good peer support, and one reason that employing more peer support staff will catalyse the paradigm shift needed to eliminate stigma and discrimination, through the power of contact[xlv].

[4] The 2017 report from OECD quotes the most recent statistics available 2009-2013. The figure for New Zealand (15.6 per 100,000 for ages 15-19) is from 2010. The most recent statistic available from Statisitics NZ (17.6 per 100,000 for ages 15-19) is from 2014.

Increasing numbers of clinicians are gaining the confidence to self-identify as having lived experience of mental distress, and this will have a powerful effect on reducing stigma and discrimination in services. These clinicians need to be supported and encouraged to blaze the trail for other people who may choose to make their lived experience into something that brings value to the community by supporting others through times of distress.

In 2005 the Mental Health Commmission published its Service User Workforce Development Strategy for the mental health sector 2005-2010[xlvi]. Much of the content of that document remains relevant but few of its recommendations have been implemented to date. We recommend this strategy be implemented fully to make immediate improvements, while system transformation is being co-designed and undertaken.

Apologise to those who rights have been denied by government-funded agencies

Trauma is often an underlying cause of mental distress and addictions. A traumatised person's healing from trauma can be greatly benefitted by a genuine acknowledgement and apology from the person or persons responsible for that trauma.

We ask that the government make a formal apology to those who suffered abuse in psychiatric institutions, as detailed in Te Āiotonga[xlvii] - the 2007 report of the Confidential Forum on abuse in psychiatric institutions, and those who subsequently contacted the Confidential Listening and Assistance Service. Many of those who sought redress via the Confidential Forum have died without ever hearing an apology for abuse they suffered. Even the report itself is now virtually hidden from public view. For those who survive, and for many others who have suffered abuse while in mental health care since 1990, an apology remains an essential step toward recovery.

The Royal Commission of Inquiry into Abuse in State Care (the Royal Commission) is only beginning, but it is well known that the impact of abuse in childhood is commonly associated with mental distress and addictions later in life.

We ask that the government broaden the terms of reference of the Royal Commission to include churches and other state-funded care providers, especially mental health services, and also make an apology to people who suffered abuse in state-funded care when that Inquiry is completed.

Provide adequate mental health support for people in prison

The United Nations Subcomittee for the Prevention of Torture (SPT) has made it clear that mental health care, and health care in general within New Zealand prisons and detention facilities is inadequate.

"*The SPT recommends that a comprehensive national policy and strategy be developed to ensure appropriate access to health care and mental health care services across the criminal justice system. A significant increase in provision of mental health services is required to cope with the high number of detainees with mental health problems*."[xlviii]

Prisoners need access to specialist mental health care when in severe distress, and the treatment they receive should be in an appropriate environment and equivalent to that for a person not in prison.

The government recently announced a proposed 100-bed mental health facility as part of the Waikeria Prison rebuild[xlix]. While a purpose-built facility with specialist mental health staff would be an improvement on current practices, the ideal would be to provide effective mental health services in all prison units.

The World Health Organsiation (WHO) does not recommend building separate psychiatric prison hospitals.

*"**Effective treatment is possible but too often the available resources are wasted:** There are many effective treatments for mental disorders, but often the limited available resources are wasted in ineffective, expensive interventions and services that only reach a small proportion of those in need. The building of separate psychiatric prison hospitals in particular is not cost-effective, because they are very expensive to run, they have a limited capacity, are associated with low release rates, and they often leave the individual with a severe and persistent stigma. Many operate outside of the health departments responsible for controlling the quality of health interventions. Furthermore, there is no evidence that these expensive hospitals improve treatment outcomes. Rather, these hospitals can put prisoners at risk of human rights violations."*[l]

We suggest that if prisoners were provided the opportunity to learn how to effectively engage in mutual peer support as part of the mental health support they receive, they would learn valuable self-care and relationship skills that could assist with reducing recidivism and improve post-release outcomes. Prisoners would then be able to support one another to a greater extent, reducing the incidence of need for acute care.

Korimana - a peer support programme developed in a partnership between Kori Hemi and Balance Aotearoa, is based on Kori's experience of over 20 years working with Māori in prisons. Balance Aotearoa is currently using Korimana in forensic psychiatric services and the community, and the feedback from service users and clincians is excellent.

Balance Aotearoa would like to explore the potential for Korimana to be used in prison environments to enable prisoners to support their own mental wellbeing.

Avoid conflating mental distress/addictions with criminality

One potential risk of a closer association between mental health and addiction services and prisons is that "failure to respond" to mental health treatment, and non-compliance with treatment or sobriety goals may become framed as "antisocial choices" or aggravating factors that deserve punishment.[li]

So-called "Behavioural Health" services can readily override the rights of people who have not committed any crime by enforcing the will of medical practitioners with the threat of incarceration. This type of coercion already occurs regularly in New Zealand the with the use of the MHA as a threat to ensure compliance of "voluntary" patients[lii].

If prisons and mental health services are ever privatised en masse, this type of arrangement is open to exploitation and the manipulation of vulnerable persons to maximise private profit for jailers and suppliers of psychiatric services and pharmaceuticals.

Instead, in any process of change, a clear human rights focus must be maintained, on improving prisoners' access to adequate treatment, maximising choice, and eliminating the incarceration of people experiencing mental distress or addiction issues who have not been sentenced to be detained for committing a crime.

Increase available employment support

The case for employment and other meaningful activity as an essential part of mental wellbeing is well established.[liii][liv] On 21 March 2018 Minister for Disability Issues Hon. Carmel Sepuloni launched the Employment Support Practice Guidelines.[lv] We recommend that employment support be provided as part of an integrated system of mental health recovery services, using these guidelines.

Improve the performance of privacy protection and complaints processes

- **Ensure sharing of mental health information with non-health agencies complies with the Privacy Act and the Health Information Privacy Code**

In some cases where people using mental health services have their private health information shared without permission, the information is shared appropriately in accordance with the Privacy Act and the Health Information Privacy Code. However, breaches commonly occur. Where information regarding mental health diagnoses and treatment is shared with non-health agencies, it can result in discriminatory practice by staff of those agencies.

Legislation, regulations and guidelines exist but are often ignored, and complaints to health providers usually result only in the complainant being referred to the the Privacy Commission or HDC. Providers need to take ownership of complaints and not simply refer people elsewhere.

The lived experience of mental health diagnosis and related information being given to agencies one has to rely upon is often an experience of being discriminated against on the basis of that information. Whether discrimination is actually ocurring or not, it is natural to wonder whether sensitive information that is known to be stigmatising has an influence on the outcomes one gets from that agency. When agencies are provided with detailed information such as diagnoses or treatment information that is not necessary for their work, discrimination is likely to be both the cause and the result.

- **Increase access to advocacy support**

We recommend more advocacy support be made available. Advocacy support can be essential for some people who experience mental distress in order to effectively access public services.

Psychiatric medications often interfere with cognitive ability and concentration, and symptoms of distress can interfere with a person's ability to remain focused, or to regulate their responses to events. Fear and uncertainty, unfamiliar circumstances and complex processes, and the high stakes involved (e.g. potential loss of income, housing, or one's children, incaceration and/or involuntary treatment) add to the pressure. This can make interactions with service staff more difficult, and if frustrations escalate, the result is often that the service user, or their perceived mental illness, is blamed.

The presence of an advocate can prevent discrimination from occurring, and enable people to manage any discriminatory practice without their response being interpreted as a result of their percieved illness. Advocates can also be more familiar with the person's support needs and circumstances and facilitate more successful interactions.

Ongoing human rights abuses such as the highly publicised case of Mr Ashley Peacock[lvi] and other similar situations[lvii] that are less publicised highlight the need for advocacy to be robust and sustained.

Acknowledgements
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"The presence of mental heath [sic] problems is often a mitigating factor in sentencing, suggesting reduced moral blameworthiness. However, in two circumstances it can also be aggravating – where the disorder is viewed as untreatable and increasing risk to the public or (more rarely) where a refusal to seek or comply with treatment is interpreted as failure to take responsibility for one's own risk factors.[highlight added] How should courts handle issues of accessibility of treatment, as well as the risk that hoped-for treatment may not ultimately be available? This theme anticipates continued pressure to respond better to mental health problems that are not sufficient to be exculpatory, but do challenge the judge in setting a sentence that responds to the multiple objectives set out in the Criminal Code."

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