REALISING A HUMAN RIGHTS APPROACH TO MENTAL HEALTH – SUBMISSION TO INQUIRY INTO MENTAL HEALTH & ADDICTION

This submission is made by the New Zealand Centre for Human Rights, Law, Policy and Practice at Auckland University.

Clearly, mental health status is impacted by a range of factors many of which are directly related to fundamental human rights. While this submission focuses on the development and delivery of mental health services, we are concerned that despite New Zealand’s longstanding ratification of international standards they are still not adequately entrenched in legislation and policy whether in relation to housing or many of the other factors listed in the Terms of Reference.

The Centre considers that the application of a human rights approach to the development of a mental health framework would improve the present system.

A copy of the report by the UN Special Rapporteur on the right to the highest attainable standard of physical and mental health which makes a number of recommendations on how a human rights compliant mental health system could be achieved is attached. Of necessity this is a generic document. The Centre has therefore tailored its comments on a human rights approach to be more consistent with the Inquiry’s TOR. While a human rights approach may not solve all the current problems, it has much to offer any reform of mental health policy and legislation. As one academic has noted:

*Human rights-based approaches should be utilized for legal and moral reasons, since human rights are fundamental pillars of justice and civilization. The fact that such approaches can contribute to positive therapeutic outcomes and, potentially, cost savings, is an additional reason for their implementation.*

The Centre also has concerns about the effect that social media is having on mental health and has attached a copy of a paper prepared by students of the Equal Justice Project identifying some of the moves that are being made in other jurisdictions to combat the negative effects of social media.

1. A HUMAN RIGHTS APPROACH

The human rights approach developed by the United Nations is a conceptual framework based on international standards. As adapted for New Zealand by the Human Rights Commission it involves:

- Taking the principles and standards in the international human rights instruments into account and identifying the rights of all those involved;
- Vulnerability – balancing the rights identified to maximise respect for all rights and right-holders and where there is conflict favouring the most vulnerable;

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• Emphasising participation & empowerment of individuals and groups, including allowing them to use rights as leverage for action and to legitimise their voice in decision-making;
• Non-discrimination;
• Transparency;
• Accountability for actions and decisions which allow individuals and groups to complain about decisions that affect them adversely.

Dealing with these standards in this context:

1.1 Compliance with the International Instruments. While many of the international human rights treaties have implications for the provision of mental health services the focus here must be the UN Convention on the Rights of Persons with Disability (“the Disability Convention”). While the human rights treaties that predate the Convention emphasise the importance of non-discrimination, none explicitly addresses many of the issues faced by persons with disabilities. For years compliance was simply assumed despite the fact that it was increasingly obvious that at times people with disabilities needed things to be done differently to achieve the same outcomes as others. The position was redressed somewhat with the introduction of the Disability Convention which reflects a paradigm change in how people with disabilities are treated moving from an approach based on a medical model, emphasising the limitations of a person’s disability, to one based on a social model which reflects their interaction with the environment.

1.2 Although the Disability Convention does not refer specifically to the involuntary treatment which distinguishes mental health treatment from conventional medical treatment, it can be read in through a number of articles including articles 14 (the right to liberty & security of the person), 17 (the right to respect for physical and mental integrity) & 12 (legal capacity). In the mental health context the notion of universal legal capacity and the associated supported decision making are particularly relevant.

1.3 The Committee responsible for monitoring observation of the Convention has criticised New Zealand’s non-compliance with article 12 suggesting that the present mental health regime needs to be revised to better respect a person’s autonomy, will and preferences - including the right to give and withdraw informed consent - as laid out in the Committee’s General Comment No.1 on equal recognition before the law.3

1.4 In order to comply with the Convention, it has been suggested that the approach to legal capacity should be the same for everyone or it amounts to discrimination. It follows that people deemed to be mentally ill should be able to exercise the right to consent in the same way as everyone else even if it is detrimental to their own wellbeing. As Genevra Richardson has put it, the underlying assumption is that ... the law must give the same status and respect to decisions made by people with mental disabilities, however great the impact of those disabilities on their decision-making, as

3 List of Issues prior to the submission of the combined second and third periodic examination of New Zealand (6 March 2018) CRPD/C/NZL/QPR/2-3
it gives to the decisions made by others\textsuperscript{4}. She goes on, however, to note that while article 12 requires that people must be provided with support where necessary to reach decisions rather than having decisions made on their behalf, it also allows it under certain circumstances which suggests that the Convention contemplates substitute decision making in some cases\textsuperscript{5}.

1.5 The issue is clearly complex but it will not be resolved by simply changing the present legislation to allow for a blanket capacity test as the Committee appears to suggest. There is some sense in the approach proposed by Professor John Dawson who has described the Committee’s views as exaggerated. He considers that less radical reforms could promote Convention compliance by adopting an approach which depended on identifying impairment in mental functions necessary to perform specific tasks. This test could be applied universally and would involve a shift away from reliance on over-broad concepts like “mental disorder” or “mental disability” but still permit the use of legal standards that rely on specific impairments in mental function – for example, driving – that are relevant to a person’s capacity. Applying this approach would not constitute discrimination in the law on the ground of disability or denial of equal recognition before the law\textsuperscript{6}.

1.6 This model could still recognise the need for supported decision-making and respect for advance directives, but substitute decision-making and treatment without consent would be permitted in certain circumstances, subject to appropriate safeguards and independent review. While such a change could be effected by amendment of the current mental health legislation it still leaves open the issue of how supported decision-making will be delivered. For example, whether it could be incorporated in a single piece of legislation (so-called “fusion legislation) or if there should be discrete legislation as in the UK.

1.7 The Protection of Personal and Property Rights Act 1988 (PPPR Act) currently provides a good framework for how supported decision-making can work in practice. While there has been criticism of the legislation as inconsistent with the Convention, the test that has been developed by the Family Court for deciding whether a person has capacity under the PPPR Act has been accepted in other jurisdictions\textsuperscript{7}. The principles governing the Act – the presumption of competence, the least restrictive intervention and obligation to help the subject person develop their capacity to the greatest extent - have gained a wide degree of acceptance and are consistent with the philosophy of the Convention. Education of mental health professionals may be necessary to ensure compatibility with some of

\textsuperscript{5} Ibid. at 346
\textsuperscript{6} Dawson, J “A Realistic Approach to Assessing Mental Health Laws’ Compliance with the UNCRPD” International Journal of Law and Psychiatry 40 (2015) 70-79
\textsuperscript{7} For example, the Mental Capacity Act 2005 (UK) s.3. In New Zealand the application of the test can be seen in X v Y [Mental Health: Sterilization] (2004) 23 FRNZ 475 (HC) (also reported as KR v MR [2004] 2 NZLR 847; [2004] NZFLR 797 (HC)
the concepts including the need to avoid making decisions in the “best interests” of the subject person rather than recognising and respecting their own wishes and decisions.

2.1 **Participation** and inclusion are basic to the Convention. In the mental health context it can be seen in the promotion of supported decision making as a way of ensuring that people have a voice in how they are treated at all stages of their care. Again, as Genevra Richardson says, this is may be an issue of best practice rather than legislation going on to note that in the UK while the importance of participative decision-making is recognised officially, a major shift in culture is still necessary to ensure a move away from the imposition of substitute decision making by professionals.

2.2 In the comment on ensuring that mental health systems are based on, and compliant with, human rights, the UN Special Rapporteur notes that the concept of participation in this area is a relatively recent phenomenon and is complicated by deeply entrenched power asymmetries in mental health systems that will only be redressed by empowering consumers.

2.3 While there have been moves in New Zealand to include consumers, whanau and family in decision making arguably it is not to the level anticipated by the Convention. Consumer participation is promoted in a number of ways – for example, Advance Directives and developments such as the recovery movement – but they tend to focus on individuals. Clearly a gap still remains. The issue is as much about social change. This might be addressed through the re-establishment of a Mental Health Commission which is dedicated to not just systemic monitoring but able to deal with wide ranging complaints or by reviewing and extending the role of the Health and Disability Commissioner to include wider monitoring and policy functions.

3.1 **Non-discrimination** is central to the Convention as people with mental illness are routinely discriminated against in many ways. Even human rights legislation such as the Human Rights Act (HRA) and the NZ Bill of Rights Act (NZBORA) is not enough to address the discrimination experienced by people with mental disability. The most pervasive example of this is arguably the existence of separate legislation which allows people with mental illness or substance addiction to be detained and treated against their will.

3.2 As noted already, the concept of capacity plays a significant role in this but it remains a poorly defined and relatively nebulous area, albeit one which can be qualified in various ways to allow for intervention when a person genuinely lacks the ability to decide on a particular course of action. While it is almost inevitable that there will eventually be a change to the existing legislation, it should be done cautiously. There is no easy answer. As John Dawson has pointed out it could be equally discriminatory not to take into account the effects of a person’s condition on their mental

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8 Supra at 353
9 A/HRC/35/21 (28 March 2017) at [44]
10 Ministry of Health A Guide to Effective Consumer Participation in Mental Health Services (1995)
functioning when making legal decisions as they may be denied some advantage – for example, providing non-consensual treatment that leads to an improvement in their health.11

3.3 The Special Rapporteur has suggested that a further problem is often not the diagnosis itself but the discriminatory patterns of care that can result. He goes on to recommend the development of a “well-stocked basket of non-coercive alternatives” that takes into account the views of the diverse stakeholders.12 Again this is something that could be facilitated by a revived Mental Health Commission or expanded Health and Disability Commission.

4. Transparency reflects the need for decision-makers to give reasons for their actions. Transparency is central to a human rights approach as there is a presumption that the ethical claims underlying human rights should be able to survive open and informed scrutiny13. This is closely linked to accountability as people cannot be held to account when information about matters such as particular treatments or the side effects of medications, for example, is not readily available. It is also a fact that people are more likely to comply with treatment or conditions imposed if they understand the reasons for it.

5.1 Accountability. Before the United Nations adopted the Disability Convention, Larry Gostin observed that:

… mental health policy quintessentially involves the exercise of government power and while such power may be exercised beneficially…governmental authority, by its very nature affects a variety of personal interests that can, and do, give rise to human rights claims when mental health powers are exercised arbitrarily, in a discriminatory manner or in the absence of fair process.14

He went on to conclude that human rights law was a powerful but often neglected tool in advancing the right and freedoms of persons with mental disabilities.

5.2 Accountability reflects the idea that those responsible for the provision of mental health services should be held to account on how they have discharged their duty. There should also be provision for some form of redress where there has been a breach. While the present legislation provides for mechanisms allowing aspects of mental health care to be questioned, it is not always the case that they function as effectively as they might. This does not mean that they are not fit for purpose but rather that they can legitimise coercion and further isolate people within the mental health system.15 For example, the requirement that a person is no longer mentally disordered before they can be discharged (the effect of the Waitemata Health case) can restrict clinicians from acting in the therapeutic

11 Dawson, supra fn5 at 71
12 Supra fn 8 at [50]
13 Amartya Sen “Elements of a theory of human rights” Philosophy & Public Affairs 32, no. 4 at 321
15 Supra fn 8 at [52]
interests of patients; or deference to the opinion of psychiatrists on Mental Health Review Tribunals can make discharge difficult.

5.3 The devolution of resources is also an aspect of accountability. It is essential that adequate funding is available for all mental health services. In this respect we wish to draw the Inquiry’s attention to the case of Ashley Peacock and others like him who have been unfairly detained, often in seclusion, for considerable periods because there are inadequate staff to deal with what can, at times, be challenging behaviours. This is unacceptable. If people are detained against their will, ostensibly in the interests of treatment, then it should be under humane and caring conditions.

5.4 The Special Rapporteur has suggested that National Human Rights Institutions should play a role in monitoring accountability arrangements and people with lived experience of mental illness, including their families and NGOs, should have a say in developing and implementing such arrangements. In New Zealand there has been an attempt to do this. The Ombudsman’s office is the designated mechanism under the Crimes of Torture Act (COTA) with responsibility for monitoring and making recommendations to improve the conditions and treatment of people detained, and to prevent torture and ill-treatment in places of detention including mental health units. This has not always been successful and the Ombudsman has recommended more formal engagement with detaining agencies on strategic planning and developments, in order to provide an independent and preventive perspective of detention in mental health and addiction services. The Ombudsman has also recommended that detaining agencies and responsible Ministries give priority to the implementation of mental health-related recommendations made by National Preventive Mechanisms and other national and international monitoring bodies.

6. In the human rights discourse, vulnerability is increasingly used to indicate the heightened susceptibility of certain individuals or groups to being harmed or wronged by others or by the State. It is particularly important in situations where popular sentiment runs against recognition of the rights of groups such as prisoners or people with mental illness. An obligation to members of vulnerable groups should be imposed on the State to ameliorate the harm of certain policies by tailoring the policies to the specific needs and concerns of those groups.

7. To sum up, the Centre considers that there would be considerable benefit in adopting a human rights approach in the development and provision of mental health services. This would require changes to the current mental health regime to better reflect the concepts in the Disability Convention including amending the definition of mental

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16 We note that there has been some progress made in Ashley’s case but it has, to quote the present Ombudsman, “been excruciatingly slow and … the time it is taking to resolve his situation is unacceptable.”

17 Ibid at [53]


19 See Palmer, G “What the New Zealand Bill of Rights aimed to do, why it did not succeed and how can it be repaired” (2016) 14 NZJPIL. At 179 he notes that the rights of unpopular people are just as real as those who live in society’s mainstream. These situations are the very ones where rights are most needed.
disorder so that it is more consistent with the concept of capacity but still allowing for some form of substitute decision making in extreme cases. The Protection of Personal and Property Rights Act, if properly implemented, has much to offer in this respect and it would be unfortunate if something that is currently working is done away with.

A human rights approach, if properly implemented, requires input from consumers and their families. While there are a number of ways this could be achieved or improved, the reestablishment of an independent Mental Health Commission would be one way of ensuring this occurs.

Finally there must be adequate, realistic resourcing of mental health services to provide good quality care for people with mental illness both as in-patients and while in the community.

8. THE IMPACT OF SOCIAL MEDIA

The rate of youth suicide is a significant concern in New Zealand but its prevention is complex and it defies simplistic solutions. A range of issues will have a bearing on the way in which it is managed.

While the Centre is not an expert in this area we would draw the Inquiry’s attention to the issue of social media and its impact on adolescent mental health. While social media has considerable benefits, for example, increased opportunities for community engagement and enhancement of creativity, it also has risks – internet addiction is now recognised in DSM-5 as a compulsive-impulsive spectrum disorder. A more pervasive concern is cyber-bullying which can contribute significantly to teenage depression20.

While a variety of tools have been developed in an effort to deal with the potentially negative effects of social media – including legislation such as the Harmful Digital Communications Act 2015 - it is an ongoing problem. A paper prepared for the Centre by the Equal Justice Project is attached. It outlines the situations in comparative jurisdictions and how they are being addressed.

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