

Under the Inquiries Act 2013
In the matter of the Royal Commission into Historical Abuse in State Care and in
the Care of Faith-based Institutions

Brief of Evidence of Dr John Adrian Crawshaw on behalf of the Ministry of Health for Institutional Response Hearing

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1 Introduction

- 1.1 My name is Dr John Crawshaw. I am the Director of Mental Health and of Addiction Services at the Ministry of Health. These are both statutory roles.¹ I have held those positions since 2011 and 2017 respectively.
- 1.2 Since 1 July 2022, I have assumed responsibility for the statutory and regulatory functions for the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, under the delegated authority of the Director-General.
- 1.3 As Director of Mental Health and of Addiction Services, I am responsible for administering Mental Health, Substance Addiction and Intellectual Disability legislation. New Zealand's compulsory treatment frameworks are strongly focused on the rights of consumers. I support services to deliver effective mental health, addiction treatment and compulsory care for their areas of responsibility and I administer protective mechanisms that aim to ensure that any compulsory intervention only reduces a consumer's rights to the extent necessary for treatment and care to be effective.
- 1.4 I have previously given evidence to this Commission, in the investigation into state abuse in psychiatric care Lake Alice hearing. I rely on portions of the brief of evidence dated 1 April 2021 for that hearing here.
- 1.5 This brief of evidence also draws from the Ministry's responses to Notice to Produce 420.
- 1.6 My background is in forensic psychiatry. I graduated from Otago University Medical School in 1978, and since 1986 have been a Fellow of the Royal Australian and New Zealand College of Psychiatrists. My previous experience includes practice as a forensic psychiatrist, lecturing in psychological medicine, and involvement in developing major changes to mental health and addiction legislation and policy frameworks in New Zealand and Tasmania. I have held a number of senior management positions, including General Manager of Mental Health, Elderly and Disability Services for Capital Coast Health (Crown Health Enterprise) between 1993 and 1998, during which time I was responsible for the closure of Porirua Psychiatric Hospital.
- 1.7 I note that in the course of my career, in a private practice capacity, I have provided expert evidence on behalf of claimants bringing claims against the Crown and Religious Institutions including issues related to limitation issues. In this capacity and in my clinical work I know all too well the depth of pain and anguish that the complaints recounted, and the long lasting impacts their experiences in care had on their lives. I also know how hard it was for them to recount their experiences and I extend my sympathy to them.

¹ Under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 respectively.

- 1.8 I am joined in giving evidence before the Royal Commission by my colleagues:
- (a) Dr Diana Sarfati, Director-General of Health.
 - (b) Dr Arran Culver, the acting Associate Deputy Director-General, Mental Health and Addiction Services.
 - (c) John Whaanga, Deputy Director-General, Māori Health.

1.9 In this brief I outline of some of the key structural changes to the health system and to the provision of mental health and psychiatric care in New Zealand since 1978. I also explain the measures that exist in the current environment to reduce instances of abuse and neglect in an inpatient context. There have been changes in the statutory landscape, the organisational structure of the public health system, and in the culture of both mental health care providers specifically and society as a whole.

2 Changes to mental health care in New Zealand

2.1 While I cannot speak to specific steps taken, I can talk about broad and significant change in the provision of mental health care that occurred in New Zealand in the latter half of the twentieth century.

Deinstitutionalisation

2.2 In the 1950s and 1960s most mental health care was provided in specialist psychiatric and psychopaedic hospitals. Care was provided on a long-term, in-patient basis. In both the health sector and more broadly across society there was an expectation that people with a range of mental health conditions should be kept in institutions rather than being members of the community.

2.3 Over time there was a growing concern, including from within the medical community, that the practice of committing patients to specialist institutions that were isolated from the community was problematic. A preference developed for providing health care in the community and for patients to have a greater degree of autonomy.

2.4 Deinstitutionalisation in New Zealand was part of an international move away from this style of providing mental health care. Although the increased risk of abuse in an institutionalised environment was one of the factors encouraging deinstitutionalisation it was not the primary one. Deinstitutionalisation was primarily motivated by a sense of optimism that providing health care in the community and with greater respect for the dignity and autonomy of patients would lead to better health outcomes. It was enabled by better treatment options for mental illness, the establishment of mental health inpatient units at general hospitals, and the provision of supported accommodation in the community.

2.5 There is a growing body of literature that suggests there is an inherent likelihood of deviation from acceptable social norms in the psychiatric institutions and other institutions as they previously operated. This arises from the very significant level of paternalism and control over a vulnerable person's life that characterised such institutions. The institutional environment affected both staff and residents – both sets of people became institutionalised. Quite aside from

the issue of abusive people in positions of power within institutions, the institutionalisation of staff and residents led to an environment in which bad practices were not challenged. This dynamic was part of the rationale behind closing psychiatric institutions completely – it was not sufficient just to introduce new policies or remove problematic individuals.

- 2.6 Deinstitutionalisation was an ongoing process covering most of the latter half of the twentieth century, and several of the changes in this brief can be considered part of the deinstitutionalisation process.

New Zealand Bill of Rights Act 1990 and international legal instruments

- 2.7 In recent decades, the increased emphasis on human rights in society and law has also had a profound impact on the way that mental health patients are treated. Many of the rights protected in the New Zealand Bill of Rights Act 1990 (**NZBORA**) are relevant to the provision of mental health care, especially when on an inpatient and/or compulsory treatment basis. The protection of these rights, and the obligation under section 6 to interpret enactments consistently with the protection of rights, have centred a rights-based approach to the provision of mental health care. This has numerous implications, such as on the use of seclusion and restraints.

- 2.8 A number of international law instruments have been adopted in New Zealand which also have particular application in this context, including:

- (a) United Nations Convention Against Torture (**UNCAT**), ratified in New Zealand in 1989, and the Optional Protocol to that convention (**OPCAT**) in 2007;
- (b) United Nations Convention on the Rights of the Child (**UNCROC**), ratified in New Zealand in 1993; and
- (c) United Nations Convention on the Rights of Persons with Disabilities (**UNCRPD**), ratified in New Zealand in September 2008.

- 2.9 UNCAT and OPCAT together provide for a system of regular visits by independent bodies to places of detention, including those detained under mental health legislation. The visits may be made without notice, which provides a greater level of assurance in the robustness of such visits. Monitoring bodies issue recommendations and conduct follow-up visits as required to progressively improve the protection of rights in places where people are deprived of their liberty. Monitoring reports from the Ombudsman responsible for monitoring mental health facilities are published to provide an added layer of accountability and transparency. The ratification of UNCROC also led to the Ministry issuing guidelines to service providers on compliance with non age-mixing provisions in article 37(c) of that convention.

Mental Health (Compulsory Assessment and Treatment) Act 1992

- 2.10 The enactment of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (**1992 Act**) initiated one of the most significant shifts in the provision of mental health care in New Zealand. The 1992 Act was a reaction to the well-known defects in the earlier mental health system, which failed to prevent

widespread abuse of mentally ill patients. The 1992 Act introduced additional protections for consumers of mental health services, including:

- (a) Redefining the circumstances and manner in which a person may be assessed of the need for treatment, and if that need is established, then how that compulsory treatment should be provided;
- (b) Emphasising consideration of the need for treatment and for the provision of that treatment in the least restrictive environment possible;
- (c) emphasising the need for powers under the Act to be exercised with proper respect for cultural identity and personal beliefs, and for consultation with family and whānau of patients and proposed patients;
- (d) an enhanced role for district inspectors;
- (e) the rights of people with mental disorder are specified and comprehensive provision was made for the review of clinical decisions about a person's mental condition;
- (f) mechanisms for patients to make complaints about breaches of their rights;
- (g) specific provisions relating to what is required to detain people under the Act; and
- (h) specific provisions relating to what is required to detain children and adolescents.

Statutory Officers

- 2.11 Among the innovations introduced by the 1992 Act was a modified structure for the administration of the legislation. The 1992 Act devolved many of the Director's powers to hospital level with the creation of the role of Director of Area Mental Health Services. It also established a process for complaints resolution at a local level that is independent of the Director of Mental Health

Director of Area Mental Health Services (DAMHS)

- 2.12 Appointment by the Director-General of Health confers upon the DAMHS a set of powers and responsibilities related to the administration of the 1992 Act in a specified area. These responsibilities can be categorised as either statutory administration or clinical oversight. In addition, the DAMHS must be able to influence operational and staffing decisions within a mental health service to operate effectively.

District inspectors

- 2.13 District inspectors are lawyers appointed by the Minister of Health but are wholly independent and cannot be employees of mental health services.² Broadly speaking, the statutory watchdog role performed by district inspectors is a form of social regulation of the state-funded providers of mental health services to mentally disordered persons who are detained for assessment and

² Section 94.

treatment. The role is justified by the extraordinary power – unique to the state – to lawfully detain and compulsorily treat mentally ill people against their will.

- 2.14 District inspectors have both a remedial and preventative effect in terms of abuse but also in terms of other issues with the delivery of mental health services. The 1992 Act strengthened the role of district inspectors through mechanisms such as:
- (a) the requirement to meet every person brought under the Act to explain their rights;
 - (b) the power to inquire into alleged breaches of a person’s rights under the Act; and
 - (c) increased requirements to visit inpatient and outpatient services.
- 2.15 In discharging this watchdog role, the district inspector has four distinct but related functions:
- (a) the provision of information and checking of documentation/processes;
 - (b) visitation and inspection;
 - (c) complaint handling and resolution; and
 - (d) conducting inquiries.
- 2.16 Monthly visits are carried out at inpatient hospitals and services, and quarterly visits at outpatient hospitals and services. District inspectors are empowered to inspect the entirety of hospitals and services in the manner and at the time they deem necessary, without giving advance notice.³
- 2.17 District inspectors have access to a range of records and registers within services to identify issues and patterns, including incident reports and restraint registers. They review incidents that are reported (over the years there has been a significant focus on encouraging the reporting of incidents). Staffing levels are also monitored during inspections, to check that appropriate care is maintained despite any staffing pressures.
- 2.18 District inspectors must report monthly to me as Director of Mental Health on their findings and observations during the course of their duties, and my role includes providing direction to them in the carrying out of their role. I have encouraged them to provide clear narratives around their observations and issues raised by patients. As I will often say to them, they are my eyes and ears about what is happening on the ground. My office monitors these reports along with various other information sources to identify trends that appear to be emerging in the provision of care.
- 2.19 A focus of my term as Director and, therefore, of the direction I provide to district inspectors, has been on developing an application of the 1992 Act that is as consistent as possible with the NZBORA and UNCRPD. I have focused on the need to ensure that patients’ rights are upheld and that vulnerable individuals

³ Sections 96 and 97.

are protected. I discuss this further in the later section under Guidelines to the 1992 Act.

Patient rights under the 1992 Act

- 2.20 Patient rights are explicitly provided for in the Act.⁴ These include rights to:
- (a) respect for cultural identity and personal beliefs;
 - (b) to be informed about treatment;
 - (c) independent psychiatric advice and legal advice;
 - (d) to receive visitors, make telephone calls, and to send and receive correspondence;
 - (e) make formal complaints about breaches of rights; and
 - (f) information about patients' rights.
- 2.21 Patients or other complainants may complain about breaches of patient rights. Such complaints are investigated by district inspectors and, if the complaint is considered to have substance the district inspector must report the breach to the Director of Area Mental Health Services and may make recommendations for action.⁵ The Director of Area Mental Health Services must take all steps to remedy the matter. Patients and other complainants must be informed of the findings of the investigation and may refer their complaints to the Mental Health Review Tribunal established under the Act for further investigation if they are unhappy with the outcome of the District Inspector's investigation. District inspectors will visit each patient to ensure they are aware of their rights, which establishes a contact with the patient that makes it easy to informally raise issues or concerns that the patient may have about their care.
- 2.22 The Ministry's approach, where complaints or district inspector investigations suggest the possibility of criminal offending, is to refer the matter to Police as the appropriate investigating agency. The willingness to involve Police at an early stage in such a situation is in my view something that has changed over the years.
- Other protective features of the 1992 Act*
- 2.23 Patients may only be placed in compulsory care in accordance with the Act. This requires the patient to be assessed and diagnosed with a mental disorder (as defined under the Act) by a health practitioner (also defined) and for the health practitioner to consider that the patient cannot be adequately assessed and treated as an outpatient. Further provisions in the Act provide that if an inpatient's responsible clinician considers at any point that they can be assessed and treated adequately as an outpatient then a process must be instigated for the patient to be discharged and treated as an outpatient.
- 2.24 Special provisions relating to children and young people include that wherever practicable, assessments of a proposed patient who is under 17 years old be

⁴ Part 6 (ss 63A-75).

⁵ Section 75.

conducted by a psychiatrist practising in the field of child psychiatry.⁶ This ensures children receive the best treatment and care by a professional who is attuned to their development and situation. In my experience the “wherever practicable” standard means that assessments are conducted by an appropriate specialist in the overwhelming majority of cases – it is the expectation.

Future reform

- 2.25 The Government has agreed to the recommendation in He Ara Oranga to repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992. This provides an opportunity to create new legislation which has greater consistency with the United Nations Convention on the Rights of Persons with Disabilities. It must also recognise Te Tiriti and support the rights of Māori as tāngata whenua.
- 2.26 Communities have recently been involved in consultation for the repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act. In particular, the Ministry refers the Commission to *Transforming our Mental Health Law: A public discussion document*.⁷ The public was invited to provide feedback via an online submission, or by answering the questions in the consultation document and emailing or mailing their answers to the Ministry. This feedback will help to develop recommendations for new legislation.

Public health sector restructures

- 2.27 The public health sector underwent a significant restructure in 1993. Prior to this restructure, the Department of Health oversaw both the provision of health services and the design of health policy. Four Regional Health Authorities (**RHAs**) were established as purchasers of health care and 23 Crown Health Enterprises (**CHEs**) as providers. The Ministry of Health was established in 1993 to replace the Department of Health, with responsibility for monitoring and regulating the provision of health care.
- 2.28 In 1998, the RHAs were combined into one national purchasing agency, the Health Funding Authority (**HFA**). The 23 CHEs were reconfigured as 24 not-for-profit Crown-owned companies and renamed Hospital and Health Services.
- 2.29 The further reforms of the late 1990s and early 2000s established the 20 district health boards (**DHBs**) that existed until 1 July this year, before being replaced by Te Whatu Ora Health New Zealand. The significant role of the Ministry as a monitor and regulator independent of the health service provider (whether RHA or DHB) has remained a consistent feature. Separating the regulator from the service provider enables more effective regulation and oversight.
- 2.30 Dr Sarfati’s brief of evidence provides further detail on the structural changes that have occurred in the health sector over the past decades.

⁶ Sections 85-90.

⁷https://www.health.govt.nz/system/files/documents/publications/transforming_our_mental_health_law.pdf

Code of Health and Disability Services Consumers' Rights

- 2.31 The Code of Health and Disability Services Consumers' Rights was implemented by the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. The Code sets out a number of rights for consumers of health and disability services, including rights to be treated with respect and dignity, and to make complaints relating to health and disability services.
- 2.32 The Health and Disability Commissioner Act was enacted in 1994 to implement the recommendations of Judge Cartwright in her 1988 Cervical Cancer Inquiry Report. The Commission, and the Code, provide important protections for consumers of health and disability services in New Zealand.

Mental Health Commission and Blueprint

- 2.33 The Mental Health Commission was set up in 1996 following an inquiry into mental health services in New Zealand by Judge Ken Mason. The Commission's purpose (as set out in the long title of the Mental Health Commission Act 1998) was (a) to ensure the implementation of the national mental health strategy; and (b) by carrying out that task, to improve services that affect people with mental illness and to improve outcomes for people with mental illness and their families and caregivers. The main function of the Commission was monitoring and reporting on key agencies' performance in relation to the implementation of the national mental health strategy.
- 2.34 The Mental Health Commission produced Blueprint for Mental Health Services in New Zealand: How Things Need to Be in 1998 (**Blueprint 1**), to guide the development of mental health services. This was an influential document that focussed on a recovery approach in service delivery and reflected the shift of thinking in the sector. Blueprint 1 called on services to "empower consumers, assure their rights, get the best outcomes, increase their control over their mental health and well-being, and enable them to fully participate in society".⁸ The Commission was disestablished in 2012.

Quality improvement systems

- 2.35 Since the late 1990s there has been a greater focus on clinical governance and quality improvement and assurance. Quality improvement systems were relatively new in the 1990s – now they are common and important. Any serious incident is investigated and learned from. If a service provider becomes aware of poor care, or of poor outcomes, it will be investigated and reported through a clinical governance process. That philosophy would not have been present historically.
- 2.36 The Health Quality and Safety Commission (HQSC) was established in 2010, following on from the Quality Improvement Committee and before that the National Health Epidemiology and Quality Assurance Advisory Committee. The HQSC's role includes leading and coordinating improvements in safety and quality in health care and reporting publicly on safety and quality. It has a programme of work to improve the quality and safety of mental health and addiction services provided by Te Whatu Ora Health New Zealand.

⁸ Blueprint 1, p vii.

- 2.37 As Director of Mental Health, I must be notified of the death of any person under the 1992 Act⁹ and I also require reporting of certain other adverse events. Part of my response is to ask how the particular issue will be investigated and how solutions to any issues identified will be implemented.

Children’s Commissioner

- 2.38 The Children’s Commissioner was established in 2003 under the Children’s Commissioner Act 2003. The Children’s Commissioner is a further independent avenue to which formal complaints may be made, including about the treatment of children and young people in care. The Commissioner also has a proactive monitoring role.

He Ara Oranga

- 2.39 In 2018 the government established an inquiry into mental health and addiction in New Zealand. The report of that inquiry, He Ara Oranga, recommended the repeal and replacement of the 1992 Act in favour of a more rights-focused approach. Cabinet has accepted that recommendation. More broadly, He Ara Oranga also emphasised the need to strengthen the voice and role of consumers and to ensure the person and their whānau are at the centre of service delivery. Ensuring there is an effective voice for consumers and their whānau will help strengthen a focus on enhancing the rights of individuals, and preventing abuse.
- 2.40 Although the recommendations in He Ara Oranga are not explicitly aimed at reducing instances of abuse, the enactment of new legislation does provide an opportunity to consider further structural protections against abuse. Some of the consultation with people with lived experience under the 1992 Act has shown that people subject to compulsory assessment or treatment continue to feel disempowered. A sense of disempowerment may be a factor that contributes to an environment in which abuse is more likely to occur. Addressing that disempowerment, including through the repeal and replacement of the 1992 Act, will be an important future objective.

Mental Health and Wellbeing Commission

- 2.41 In line with a recommendation in He Ara Oranga, the Mental Health and Wellbeing Commission was established in February 2021, following the establishment of an initial Mental Health and Wellbeing Commission in late 2019. The Mental Health and Wellbeing Commission’s functions include:
- (a) assessing and reporting publicly on the mental health and wellbeing of people in New Zealand;
 - (b) making recommendations to improve the effectiveness, efficiency, and adequacy of approaches to mental health and wellbeing;
 - (c) promoting alignment, collaboration, and communication between entities involved in mental health and wellbeing;

⁹ Section 132.

- (d) monitoring mental health services and addiction services and advocating improvements to those services; and
 - (e) advocating for the collective interests of people who experience mental distress or addiction, and the persons (including family and whānau) who support them.
- 2.42 The Commission must have particular regard to the experience and outcomes for Māori when performing its functions. It must also maintain systems and processes to ensure that it has the capability and capacity to uphold the Te Tiriti o Waitangi and its principles, to engage with Māori, and to understand Māori perspectives.

Guidelines under the 1992 Act

- 2.43 The Ministry issues guidelines under s 130 of the 1992 Act. In September 2020 the Ministry produced a revised set of guidance: *Guidelines to the Mental Health and Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992 and Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992* (together, **Guidelines**).
- 2.44 The Guidelines are intended to promote the protection of compulsory mental health consumers' rights by clarifying the responsibilities of mental health services and clinicians and offering guidance on how sections of the Act can be administered. The guidelines include reference to the principles of Te Tiriti o Waitangi, equity, preservation of human rights, and the significance of cultural identity to the provision of mental health care. The September 2020 guidelines include particular updates to take into account:
- (a) the growing significance of a rights-based approach to operating under the Act;
 - (b) the need to give greater emphasis to obligations under Te Tiriti o Waitangi;
 - (c) The impact of He Ara Oranga and in particular, feedback from people with lived experience, as well as their families and whānau, on their experience of the 1992 Act.
- 2.45 The September 2020 revision of the Guidelines arose from a joint action between the Ministry and Disabled People's Organisation *Balance Aotearoa* in the Disability Action Plan 2014-2018. This was part of the Ministry's response to concerns raised about the alignment of human rights principles and the 1992 Act.
- 2.46 He Ara Oranga reiterated similar concerns about the application of human rights and use of compulsory and coercive treatment, ultimately recommending a repeal and replacement of the Mental Health Act, which is now almost 30 years old.
- 2.47 The first chapter (a new chapter) of the updated guidelines sets out expectations around how clinicians applying the 1992 Act can align their practice with Te Tiriti. This chapter was developed in consultation with the Māori Health Directorate and references the five principles identified by the Wai2575 Inquiry

and the Ministry of Health's *Whakamaua: Māori Health Action Plan 2020-2025*. The principles are as follows:

- (a) **Tino rangatiratanga** underpins the principles identified in Te Tiriti. It is often translated as 'self-determination' or 'sovereignty'. It means that Māori are guaranteed self-determination and mana motuhake in the design, delivery and monitoring of health and disability services – this means the right to be Māori, and to live on Māori terms in accordance with Māori philosophies, values and practices.
 - (b) **'Partnership'** is recognised as a relationship between the Crown and Māori, in which they act with respect towards one another, work together, and are flexible about different structures where organisations are not meeting the needs of one another. Partnership requires the Crown and Māori to work in partnership in the governance, design, delivering and monitoring of health and disability services. Māori must be co designers, with the Crown, of the health and disability system for Māori.
 - (c) **'Active protection'** requires the Crown to act, to the greatest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner are well informed on the extent and nature of both Māori health outcomes and efforts to achieve Māori health equity.
 - (d) **'Options'** requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
 - (e) **'Equity'** requires the Crown to commit to achieving equitable health outcomes for Māori. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.
- 2.48 The guidelines emphasise the importance of Te Tiriti in relation to particular relevant sections, including sections 5 (respect for cultural and personal rights), 7A (obligation to consult family/whānau), 65 (respect for cultural identity), and 66 (right to treatment) of the 1992 Act.
- 2.49 The Ministry of Health, as steward and kaitiaki of the health system, has a responsibility to enable Māori to exercise authority over their health and wellbeing, to achieve equitable health outcomes for Māori, in ways that enable Māori to live, thrive and flourish as Māori. The Ministry and all publicly funded health services are obliged to acknowledge and apply Te Tiriti o Waitangi articles and principles in their policies and practice.
- 2.50 To influence practice change, the Ministry is working with Te Pou (a government funded national workforce centre for mental health, addiction, and disability services) to design training programmes for people who administer the Mental Health Act. Through this partnership we have emphasised the following priorities in designing training programmes:

- (a) an emphasis on the least restrictive practice when applying legislative powers;
- (b) culturally safe and appropriate care;
- (c) supporting patients and proposed patients to make their own decisions;
- (d) equity in the use of compulsory assessment and treatment;
- (e) person-centre and recovery-based approaches to the use of compulsory assessment and treatment;
- (f) engagement with family and whānau; and
- (g) accountability and transparency.

2.51 The Ministry first started reporting on differential use of restrictive care by ethnicity in 2011. Since this time, we have found that Māori are more likely to experience compulsory assessment and treatment than non-Māori and are also more likely to be secluded. As a result, DHBs (now Te Whatu Ora Health New Zealand) are required to address this disparity. There is also an active goal to reduce the number of Māori subject to community treatment orders, which is reported on in annual plans.

3 Lessons learned

- 3.1 The provision of mental health and disability care in New Zealand, and the associated regulatory framework, has been one of ongoing evolution. This has reflected transformations in society about the type and standard of care that should be provided, and advances in care reflecting improved understanding (whether clinical, scientific or social services).
- 3.2 It has also reflected the ongoing and improved recognition of the rights of persons in care, including the New Zealand Bill of Rights Act 1990, Human Rights Act 1993 and international instruments (such as the United Nation Convention of Rights of Persons with Disabilities). This does not only reflect changes in society at large, but also as a result of reviews (including inquiries) over time into care provided and the need for change. The Mason Report in 1988 and the subsequent response, including the enactment of the Mental Health (Compulsory Assessment and Treatment) Act 1992, is an example of this.
- 3.3 Most recently, we have seen the publication of the 2018 Inquiry into Mental Health and Addiction, the publication of the Inquiry report and the government response to that Inquiry. It recognises the ongoing evolution of a rights-based approach to care and seeking elimination of abuse in care, which it is acknowledged historically occurred and is recognised in the report of the 2005 Confidential Forum for Former In-Patients of Psychiatric Hospitals (the Forum). This was succeeded by the Confidential Listening and Assistance Service (the Service) in 2008. Participants in the Forum and the Service highlighted abuse that they had suffered while in care in state-run psychiatric hospitals and facilities.
- 3.4 Those actions also reflect where failures in care, including abuse, or outdated practices have been identified, as well as the need for change. It also means that

the current health and disability system has had significant change over the years, as well as staff within it.

- 3.5 In the 1950s through to the 1970s people (including children and young people) were placed in institutions for reasons that would not be acceptable today. This shift in attitude is consistent with an increasing societal focus on a rights-enhancing environment that has gone hand in hand with the formal changes, which together makes it much more difficult for abuse to occur at a systemic level. While those formal changes have established measures for reducing incidents of abuse and neglect, the impact of changes in social norms since the 1970s should also not be underestimated. Historically society has displayed significant stigma towards people with mental illness and intellectual disabilities, and while stigma continues to be a problem today, the shifts in attitude have been enormous. Significant portions of the community strongly opposed the idea that mental health care should be provided in the community, which at times created obstacles to progress.
- 3.6 The emergence of the mental health consumer rights movement was instrumental in challenging the prevailing beliefs and practices in psychiatric institutions and advocating for the rights of service users. Advocacy groups such as the Mental Health Foundation (1977) were also influential in changing public attitudes towards mental illness and promoting the rights of service users.
- 3.7 In the mid-1980s I established a group representing the region's psychiatrists called Wellington Regional Psychiatrists. In response to the calls for changes, one of our activities was advocating for shutting the Porirua Psychiatric Hospital. I experienced first-hand the resistance of some parts of society and key agencies, which did not always accept that institutionalising people for mental health reasons was unacceptable. That is the backdrop against which large-scale psychiatric and psychopaedic institutions were situated, and just as significantly it was the context within which measures to prevent abuse had to be introduced.
- 3.8 Related to these societal changes is the distinction between staff behaviour that was inappropriate and abusive at the time on the one hand, and clinical practices that would not be acceptable today but were consistent with practice at the time. The nature and standard of care and treatment provided in historical psychiatric or psychopaedic institutions would be unacceptable today, and might extend to neglect or abuse in today's environment. These institutions, because of the large numbers of patients and often low staff numbers, operated a more regimented and standardised system of care than would be acceptable today. This meant that people often lost independence and individuality.
- 3.9 While of course not all people involved in such institutions were problematic, and many were motivated by the desire to help people, the reality is that these institutions had many negative consequences. For that reason, there was a big push to shut the institutions, including by psychiatrists of my generation and other health care professionals. There is however a distinction between that treatment, historically within normal practice and now viewed as inappropriate, and behaviour that, then as now, was abusive.

3.10 Treatments are another area in which there has been significant change over time. In the 1950s-1970s there was limited psychotropic medication available. Although able to provide positive effects in some cases, these agents often had significant side effects and limited effectiveness by today's standards. By the 1980s and 1990s more effective medications had been introduced, with a lesser side effect profile. The advent of these new medications combined with the move towards community care to enable discharge back into the community and the whole deinstitutionalisation movement. Thankfully we have a greater range of pharmacological and other psychological treatment options available to us now.

Signed: 

John Adrian Crawshaw

Date: 