

**The road to the Royal Commission and beyond:
Mental health services**

**Statement to the Royal Commission of Inquiry into Historical Abuse
in State Care and in the Care of Faith-based Institutions**

Contextual Public Hearing

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Contents

Introduction	5
Historical context	5
<i>Institutional services</i>	5
<i>After deinstitutionalisation</i>	6
<i>The psychiatric survivor movement</i>	7
Background to abuse	8
<i>Defining abuse</i>	8
<i>The underlying dynamics of abuse</i>	9
<i>Sources</i>	10
<i>Why people went into mental health services</i>	10
Nature of abuse	11
<i>Environmental abuse</i>	12
<i>Procedural abuse</i>	14
<i>Legislative abuse</i>	15
<i>Treatment abuse</i>	16
<i>Psychological abuse</i>	18
<i>Physical abuse</i>	18
<i>Sexual abuse</i>	19
<i>Cultural abuse</i>	20
<i>Property abuse</i>	21
<i>Narrative abuse</i>	21
Impact of abuse	22
<i>Ongoing trauma</i>	22
<i>Poor life and health outcomes</i>	23
<i>Broken whānau and community connections</i>	24
<i>Impact on Māori</i>	25
Mental health services after 1999	25
<i>The dominance of clinical approaches</i>	26
<i>Continuing institutionalisation</i>	26
<i>Rising rates of compulsory treatment</i>	26
Changes to stop abuse	27
<i>UN Convention on the Rights of Persons with Disabilities</i>	27
<i>The UN Declaration on the Rights of Indigenous Peoples</i>	28

<i>Inquiries, compensation and apologies</i>	28
<i>Review and complaints mechanisms</i>	28
<i>Eliminating seclusion and restraint</i>	29
<i>Advance directives</i>	29
E Kore Anō – Never Again	29
<i>Redress and rehabilitation</i>	30
<i>Conclusion</i>	33
Bibliography	34

Beyond Locked Doors

By standing on the corner of my bed and leaning forward
I can see, under the awning and above the high fence,
A double-breasted hill nipped by trees and
A bird in flight

And I can and do stand there,
ignoring cricked neck and wobbly feet,
to affirm that beyond locked doors
Birds fly free

Monica Cartner
Easter 1991

Introduction

I was admitted to several psychiatric wards and hospitals in my 20s. The services I used did not help me and they prolonged my distress. A psychiatrist gave me a prognosis of doom at the age of 21. I'm very happy to report that his predictions about my future were wrong; I have not experienced a major episode of distress since my late 20s, I no longer take treatments, I have had a bigger career than I would ever have dreamed of and I haven't passed on any 'mental illness' genes to my children.

Despite the stripping of my status, credibility and dreams, the over-drugging, the long-polished corridors and the absence of any useful support, I was one of the lucky ones. I narrowly escaped compulsory treatment, my longest stay in hospital was three months and I had the confidence to question psychiatric narratives and regimes.

However, I witnessed psychiatric abuse and I have come across many stories of it since in conversations, films and written accounts, in my own research and on the formal record.

Abuse and neglect have been a part of New Zealand's mental health system since it was established in the 1840s. Much of the abuse was not due to the ethical lapses or incompetence of a few but to the routine practices of many. It's important to remember that not everyone experienced abuse within mental health services and some benefited from these services. But it is equally true that abuse has been widespread, especially in institutionalised and coercive services and for Māori, and marginalised populations such as Pacific people, Rainbow people and women. Abuse in mental health services continues to this day.

This paper outlines the historical background of mental health services in New Zealand to 1999. It discusses the nature of abuse in mental health services, people's experiences of it and the impact it had on their lives. It then outlines mental health developments and efforts to address abuse since 1999. It finishes with some suggestions for redress and rehabilitation.

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Historical context

Institutional services

1. The road to the Royal Commission has a long history in Western culture. Individuals with mental distress have suffered and protested their treatment at the hands of communities, the church, the state and psychiatry for centuries. They have been subjected to witch hunts, chains, ostracization, confinement and an array of cruel and desperate treatments. Through the centuries, explanations for madness and the

methods for silencing it have changed, but the discrimination that leads to abuse has to a large degree persisted.

2. The concept of 'mental illness' used in Western medicine did not exist in traditional Maori society; it was imported as part of the colonial infrastructure of New Zealand (Cram, F., Te Huia, B., Te Huia, T., Williams, M., Williams, N., 2019). The first brick in New Zealand's mental health system was laid in 1844 when 'pauper lunatic asylums' were set up next to jails. The first Lunatics Ordinance followed in 1846 which authorised the detention of 'lunatics' in jails or asylums. A network of stand-alone provincial asylums was built in the 1860s and 1870s. Over the next 100 years New Zealand's mental health services remained institutionally based. Humanising reforms such as the building of more homelike villas and community amenities inside mental hospitals from 1903, legislation allowing for voluntary admissions in 1911, and the establishment of the first outpatient services after 1925, were sporadic and did not significantly change the institutional nature of services (Brunton 2003; 2005).
3. New Zealand psychiatric hospital numbers peaked in 1944. Planning for new psychiatric hospitals stopped in 1963 and bed numbers were capped in 1973 (Brunton, 2003). At the same time there was an expansion of community-based treatment and inpatient units attached to general hospitals. By 1997 all the large psychiatric hospitals had closed.

After deinstitutionalisation

4. Part of the impetus for the closure of psychiatric hospitals was human rights concerns, but another was the misguided belief that community-based services would be less expensive (Brunton, 2003). As the hospitals began to close in the early 1990s the money did not always follow into new services and a crisis led to the 'Mason Review' into mental health services in 1995-96 (Mason, Johnston & Crowe, 1996). As a result of this review and the establishment of the Mental Health Commission, the government increased funding for community mental health support services over the next decade (Mental Health Commission, 2007).
5. In anticipation of the closure of the long stay hospitals, New Zealand passed the current Mental Health (Compulsory Assessment and Treatment) Act in 1992 which tightened the criteria for committal, introduced compulsory community treatment and developed legal procedures for people to appeal to be released from the Act (Ministry of Health, 2006).
6. Around the end of the 2000s the new funding stream for community mental health services subsided, a new government paid less attention to mental health, and leadership was lost through the reduced powers of the Mental Health Commission. Another crisis gathered over the next decade. Unlike the crisis of the 1990s this was not focused on people newly released from long-stay hospitals but on the twenty percent of the population who in any given year experience 'mild to moderate' distress (referred to as the 'missing middle'). A public outcry that people could not get the help they needed, and deep concern about rising suicide rates, led the incoming Labour-led Coalition government to announce an inquiry into mental health and

addiction in late January 2018. The inquiry panel released 'He Ara Oranga' in late November 2018 which recommended an expansion of primary mental health services (Government Inquiry into Mental Health and Addiction, 2018). This was followed by the largest budget boost for mental health in New Zealand's history – mainly for services for the 'missing middle'.

7. The history of mental health services in New Zealand is marked by bursts of new money, enthusiasms and good intentions followed by erratic or un-sustained reforms (Brunton, 2005). It is still too early to know if the latest reforms will end abuse and ensure equality, freedom and human rights for people who experience extreme mental distress. There is a risk, with expanded primary mental health services, that attention will move away from the people who are most vulnerable to psychiatric abuse – the three to five percent of the population who in any given year use specialist mental health services.

The psychiatric survivor movement

8. Psychiatric abuse propelled the development of the international psychiatric survivor movement in the 1970s, along with other liberation movements of that decade. The movement started in coastal USA, Canada and Northern Europe in the early 1970s. It called for an end to forced treatment, the dominance of psychiatry and institutionalisation. Many people who participated in the psychiatric survivor movement had experienced psychiatric abuse – actions that had harmed their bodies, minds, spirit, self-worth and standing in the world. Many of these actions were done lawfully and within the boundaries of acceptable practice. They ranged from seclusion, forced medication, locked hospitals, physical force, emotional neglect, degrading conditions, the pathologizing of human distress, prognoses of doom and the crushing invalidation of lived experience insights (Chamberlin, 1978).
9. The psychiatric survivor movement did not reach New Zealand until the mid-1980s. Over a short time, survivors set up several local networks that provided support and advocacy and the first national network was established in 1990. Since then the movement has dissipated; independent survivor led networks have dwindled as more people with openly acknowledged lived experience of mental distress have worked within the mental health system to create change, as leaders, advisors, advocates, researchers, educators and peer support workers (O'Hagan, 2014). One recent development has been the establishment of Te Kete Pounamu, a national Māori tangata whaiora network set up to improve outcomes for Māori with mental distress.
10. Since the mid-1980s the psychiatric survivor movement and activities led by people with lived experience have continued to challenge abuse in mental health services. Some highlights include:
 - Advocacy in response to the 1987 Interest Scandal¹ and leadership in the formation of the Frozen Funds Charitable Trust Board, which subsequently

¹ relating to interest on patient's welfare benefits which was paid into psychiatric and psychopaedic hospital trust accounts, but kept by the institutions and then used for recreational purposes

disbursed the residual interest money that was not paid to patients in psychiatric hospitals.

- Leadership in the Like Minds, Like Mine Programme to reduce prejudice and discrimination against people with mental distress, starting in 1997.
- Participation in drafting the UN Convention on the Rights of Persons with Disabilities in the early 2000s.
- Petitions to the government to end Electroconvulsive Therapy (de Jonge, 2003).
- Pressure on the government to establish the Confidential Forum for Former In-patients of Psychiatric Hospitals and to make a public apology.
- Publications to end compulsory interventions (Minkowitz, 2006; O'Hagan, Divis and Long, 2008).
- The 'End Seclusion Now' campaign in 2014 and participation in system-led projects to reduce and eliminate seclusion.
- Participation in the 'He Kore Anō' campaign that led to the establishment of the Royal Commission into Abuse in State Care and in the Care of Faith-based Institutions.
- Research and raising awareness of the harm caused by psychotropic drugs (Larsen-Barr, 2016).
- The development of the Wellbeing Manifesto in 2018 which called for an end to health-led services (O'Hagan, 2018).

Background to abuse

Defining abuse

11. The Royal Commission terms of reference define abuse as 'physical, sexual, and emotional or psychological abuse and neglect that results in serious harm to the individual'² This definition conceptualises abuse by the type of impact it has on the person but does not capture the many different contexts or forms of abuse that are part of coercive and institutionalised services. In the mental health setting these different forms of abuse may include:

- Environmental - institutionalisation, solitary confinement, and separation from whānau.
- Procedural - processes such as admission and administration of treatment.
- Legislative - the use of legal coercion, particularly beyond the scope of the law.
- Treatment - psychiatric remedies that are forced and cause harm.
- Psychological - bullying, threats, cruelty and put-downs.
- Physical - hitting and physically forcing people.
- Sexual - non-consensual sexual contact or harassment.
- Cultural - colonisation, racism and denial of access to cultural worldviews and supports.
- Property - withholding or stealing money or goods.

² Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018: 6

- Narrative – prognoses of doom and a focus on deficits.
12. These forms of abuse are discussed in more detail in the ‘Nature of abuse’ section. Some of the quotes may not reach the threshold for abuse as defined by the Royal Commission but they were all preventable and had a negative impact on the survivors concerned.

The underlying dynamics of abuse

13. Why has abuse in mental health services been allowed to happen so often and for so long? Why does the community accept abuse for one group of people but not for others? There’s a profoundly simple answer to this – extreme states of mental distress have zero status as a human experience, and this taints most human responses to it. It doesn’t matter if the response shows itself as fear, hostility, control, incomprehension, paternalism or pity – they all trace back to the ancient taproot of stigma.
14. Stigma strips people of their human status and sets the stage for discrimination, human rights abuses and social exclusion. Throughout history and across cultures the ways and means of expressing stigma have varied. Over the last 200 years in the West the official expressions have been institutionalisation, compulsory interventions, the dominance of medicine, and for Māori the processes of colonisation.
15. Erving Goffman described institutions as closed places where people live full-time under one authority. The environment is highly standardised and dictated by rules and schedules that discourage individuality. The inmates are often not free to leave and contact with outsiders is carefully controlled (Goffman, 1961 pp5-7). The imposition of the closed, authoritarian nature of institutions on a stigmatised group is a recipe for abuse. Institutionalisation continues today in some staffed community housing, short stay acute hospital inpatient units, rehabilitation units and a growing network of forensic units.
16. Institutionalisation has been supported by legislation that detains people and forces treatment on them. People did not have any access to legal processes to contest their loss of freedom until the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Those in charge of the institutions, the asylum superintendents, evolved into the medical specialty of psychiatry, which took its place at the hub of the mental health system. Psychiatry continues to dominate the discourse through the narrow lens of pathology, diagnosis and treatments, uses most of the resources for institutional and clinical responses, and willingly acts as an enforcer of compulsory detention and treatment on behalf of the community.
17. The mental health system has been a part of a colonising infrastructure which has imposed additional harm on Māori. Prior to the 1960s few Māori were admitted to mental health services. However, between 1959 and 1987 the number increased significantly. Throughout the 1990s and into the 2000s Māori continued to be disproportionately represented in statistics for mental health admissions, involuntary

treatment and seclusion (Mental Health Commission, 2007; Ministry of Health, 2006; Ministry of Health, 2019). In 1991 Dr Erihana Ryan described the disproportionate rate of distress amongst Māori as ‘fundamentally an expression of colonization’ (Dow cited in Cram et al, 2019:112).

Sources

18. History is written by the powerful; there are very few New Zealand narratives from people who used mental health services before the mid-20th century.
19. I quote from several anthologies, memoirs and a podcast from the last 60 years (Frame, 1980; Frame, 1984; Leibrich, 1999; Peterson and Gordon, 2009; O’Hagan, 2014; and Bidois, 2019).
20. I also draw on summaries of accounts by survivors from the 1950s on in the following reports:
 - The Report of Sir Rodney Gallen on the Lake Alice Abuses (Gallen, 2001) which described systematic violence and torture of children at the hospital’s child and adolescent unit in the 1970s.
 - *Te Āiotanga* - the report of the Confidential Forum for Former In-patients of Psychiatric Hospitals (Mahony, P., Dowland, J., Helm, A. & Grieg, K., 2007) that heard the stories of over four hundred survivors who experienced abuse in all major institutions from the 1940s to the early 2000s.
 - *Some Memories Never Fade* - the final report of the Confidential Listening and Assistance Service (Henwood, 2015), which also provided a forum where survivors could speak about experiences of abuse in state care. Around 20% of the 1100 survivors who participated reported abuse in psychiatric care or health camps.
 - Other reports and information including the Wai 2575 report *Oranga and Maori Health Inequities 1769-1992* (Cram et al, 2019) and *He Ora Oranga* (Government Inquiry into Mental Health and Addiction, 2018).

Why people went into mental health services

21. Although a purely medical view would suggest that mental distress is a brain disease, many survivors explain it differently. In the Confidential Forum and the Confidential Listening and Assistance Service people talked about poverty, family violence, sexual abuse, adverse life events and the stress that led to involuntary detention and treatment. This is backed up by research evidence that many people who use mental health services have experienced trauma (Te Pou o te Whakaaro Nui, 2018).
22. The reasons for admission varied for different groups:

Māori

23. Maori are 15% of the population but make up 25% of people who use mental health services. Māori experienced increased rates of admission and involuntary treatment after the 1960s. While these increases are in part reflected by Māori urbanisation,

evidence indicates that colonisation and systemic racism were ultimately responsible. (Cram et al, 2019).

Other groups

24. According to the Confidential Forum and the Confidential Listening and Assistance Service:

- Women and girls' admissions appear to have reflected prevailing norms about women's gender roles, mothering, pregnancy, miscarriage, childbirth and marital difficulties. Some were sent following experience inside the social welfare system. Young women admitted to psychiatric hospitals for post-partum depression often stayed for many years.
- Infants and young children were sent to psychiatric hospitals, sometimes in response to abuse within the family.
- Men and boys often experienced involuntary treatment following a trajectory of traumatic experiences through the social welfare system and/or getting into trouble at school or with the law.
- Disabled people and people with physical health conditions were also subject to forced treatment.
- Gender identity and sexual orientation that did not meet the norm also led to forced treatment.

(Henwood, 2015; Mahony et al, 2007).

Nature of abuse

25. The record shows that abuse in mental health services was multifaceted, and often part of legally sanctioned routine practice (Gallen, 2001; Henwood, 2015; Mahony et al, 2007). This is well illustrated by a conversation I had with Hinewai in the 1980s:

Hinewai, [was] a thin, haunted Māori woman in her late thirties who lived in a boarding house and blamed herself for bringing shame on her family.

'I was in the female secure unit,' she told me. 'The closed wing had seven cells with nothing but a plastic mattress and, if you were lucky, a blanket and a pillow. Girls were locked in those cells for thirteen and a half hours out of every twenty-four. There were no toilets in the cells so we had to ask the staff to let us out. Sometimes the staff were too busy playing cards or having a smoke. On at least four occasions I was forced to go on the floor like an animal. It was the ultimate in degradation.'

Hinewai wiped her eyes and rolled a cigarette. 'We spent the rest of the time in a small dayroom. There was a small courtyard to walk around if the weather was fine, but we could spend weeks in that wing without getting any fresh air.'

'What was the open side of the ward like?' I asked.

'It wasn't much better. It was still locked but you could wear clothes. There was nothing to do on the open side except watch television and smoke. If you were good you might get up to two hours ground parole in the afternoon. Most of the nurses never had time to speak to the patients. You're basically there to look after yourself. Most of the girls were drugged up to four times a day. One of my friends was on thirty-one pills a day.'

'Did you ever complain?'

'There was a lot of physical abuse from the staff. You couldn't have any emotions in this ward. Crying got one woman put in an arm lock and thrown into seclusion. Twice I was stripped naked by male nurses and dragged down the corridor by my ankles. When I got the police to investigate, they said they wouldn't lay charges because I was a committed patient. So the physical abuse just continued.' (O'Hagan, 2014, pp 144-5).

Environmental abuse

26. Environmental abuse includes institutionalisation, locked wards, solitary confinement, and separation from whānau.

Institutions

27. The Confidential Forum reported that the physical environments of psychiatric hospitals were bleak and depressing. A former staff member from Tokanui Hospital described how people were housed in large, mixed age and gender dormitories.³ Hospital buildings were sterile, barren, bleak, lifeless, institutional and often neglected by health authorities. Families too spoke of forbidding buildings, dirty, noisy, smelly environments; smoke-filled rooms; lack of privacy; and of patients not wearing their own clothes. (Mahony et al, 2007).
28. Janet Frame wrote about the depersonalising, closed psychiatric institutions in the 1940s:

There was a personal, geographical, even linguistic exclusiveness in this community of the insane who yet had no legal or personal external identity – no clothes of their own to wear, no handbags, no purses, no possessions but a temporary bed to sleep in with a locker beside it, and a room to sit in and stare, called a dayroom. Many patients confined in other wards of Seacliff had no name, only a nickname, no past, no future, only an imprisoned Now. (Frame, 1984 pp 72-73).

29. I worked as the coordinator of Psychiatric Survivors support and advocacy services in Carrington Hospital in 1988:

Most of the wards at Carrington were shaped like a big T, with a long corridor running down towards the dormitory. First there was the nurses' station, then

³ Robyn Klos, Chief Executive IHC, Return to Tokanui by Lester Thorley, Waikato Times, July 8 2006.

came the little kitchen which was locked most of the time so the patients couldn't make a mess or burn themselves. The drug room was opposite. Then came the dining room which always smelt of overcooked cauliflower. Next up the corridor was the patients' living room which usually had a ripped pool table in the middle and people sitting on chairs, chain smoking and looking blankly at the wall. Next were the bathrooms with no shower curtains or door locks. They faced the laundry, the property rooms and the seclusion rooms. At the end of the corridor came the institutional sleeping arrangement for boarding-school children, the homeless and the mad – the dormitory. (O'Hagan, 2014, p 169).

30. Alasdair Russell talked to Julie Leibrich about the prisonlike conditions in Oakley Hospital in the early 1970s:

In the five years I was in Male Three I went through 22,000 locked doors. Every door I went through was locked. I mean your cell door was locked. The door up to the stairs to the cell rooms was locked, the door at the bottom of the stairs was locked. The tea room door was locked. The day room door was locked. The kitchen door was locked. The dining room door was locked. Every door you went through was unlocked before you and locked after you. (Leibrich, 1999, p 164).

Solitary confinement

31. Solitary confinement, otherwise known as seclusion, is the placing of a person in a bare room without the ability to make an exit. It continues to be routine practice in institutional settings. Survivors at the Confidential Forum and the Confidential Listening and Assistance Service talked about solitary confinement as extremely frightening and retraumatising. Threats of solitary confinement were also routinely used to instil fear and control people. (Mahony et al, 2007; Henwood, 2015).
32. Denise Caltaux talked about her experiences of physical restraint and solitary confinement in the early 1990s:

They committed me to Tokanui and that was the worst, worst, worst thing. For a start, I was taken straight into an isolation unit, and I was strapped down until I was in a side room. Of course we were going through the rigmarole of having to strip naked – and if you don't do it they'll do it for you sort-of-thing – and not being allowed to be left with your knickers or your socks or anything like that, and being left in this place. Nobody came to speak to me for ages. There was some interesting graffiti on the wall like 'Motel Hell', or something like that, and I thought afterwards, that's not wrong. (Leibrich, 1999, p 35).

33. Egan Bidois talked recently on a podcast about the over-medication and abuses that led to him being put into solitary confinement at Tokanui Hospital in 1990:

A couple of orderlies would pick me up from my room and shuffle-drag me to the day room. They would sit me in a chair and pretty much leave me there to drool all over myself. I couldn't move. I couldn't speak. If you are unable to ask someone to help you go to the toilet, it eventually happens and someone notices the smell. If you're lucky they take you to the showers, get you cleaned off and take you to the day room again. A couple of times you would be dragged out to the front yard. You would be stripped down, hosed and given a bit of a kicking for being a filthy mongrel and tossed into a seclusion room as a punishment. (Bidois, 2019).

Separation from family and whānau

34. According to the Confidential Forum survivors were often forcibly parted from whānau, parents, partners or siblings. Contact with families and whānau was infrequent. Some whānau were told by staff that it would be best to stay away (Mahony et al, 2007). Separation from whānau left survivors more vulnerable to abuse.

35. Anne Helm was incarcerated in several psychiatric hospitals in the 1970s:

Remember, these were places where outsiders in the form of visitors were rarely seen. (Peterson and Gordon, 2009, p 188)

36. Alisdair Russell also said:

Very few people visited me in Oakley, because they never thought I would get out and I was just a nutter. It hurt. But in a way it was just par for the course, you know; it's just they don't understand. (Leibrich, 1999, p 164).

Procedural abuse

37. Procedural abuse includes processes such as admission, assessment and administration of treatment.

38. Many survivors talked to the Confidential Forum and the Confidential Listening and Assistance Service about forceful, cruel and brutal admission processes. They often had no idea why they had been admitted to hospital. They were subjected to decisions made by others, not informed of their diagnosis and received treatment without informed consent. Survivors reported rarely seeing a doctor or seeing multiple different doctors over time. They also recalled being routinely observed and written about, in clinical records, based on nurses and psychiatrists' judgements rather than their own experiences. Survivors used terms such as 'terrified', 'alone', 'abandoned' and 'confused' to describe their experience of psychiatric hospitalisation. Many survivors spoke of a general lack of communication, interaction and interest from staff. They also described widespread lack of care and compassion, ranging from indifference to overtly violent behaviour (Henwood, 2015; Mahony et al, 2007).

39. The Confidential Forum reported that people's experiences of trauma or adversity were usually disregarded in the assessment and treatment process. Survivors often

said that they were not listened to and their experiences were disbelieved. Sometimes staff did not know important details about survivors, for instance, that they had children. (Mahony et al, 2007). Institutional procedures were especially harmful for Māori who have talked about having indigenous knowledge, values and experiences pathologized and medicated, resulting in a loss of Māori identity (Bidois, 2019; Mahony et al, 2007).

40. I interviewed Veronica in the 1980s who talked about dehumanising institutional processes:

Veronica talked about being in seclusion without toilet facilities and peeing on the floor because the staff didn't check her regularly enough to let her out in time. She talked about drugs and how in many cases they violated people's bodily rights. And she talked about the nurses who sat smoking in the office reading about the cardboard characters they had created in the patients' files, while the real live people milled around waiting for the nurses to come and talk to them. I agreed with Veronica that the files are not really about us. She said hers might as well be thrown in the rubbish bin – they knew so little about her because they never really tried to find out. (O'Hagan, 2014, p 142-3)

41. I also discovered that community facilities could become institutionalised when I visited Steve at one of the 'better' boarding houses in Auckland in the 1980s:

Steve greeted me and we sat on the veranda while he rolled a cigarette. 'I'm in a room with five beds,' he told me. 'One man goes to bed at six o'clock in the evening. We can't turn the radio or lights on in case there's a fight.' He took a deep draw on his cigarette and looked into the distance. 'You know, doing nothing is hard – it gets boring here. All the people I know are on the injection. I can't play the piano after midday because the TV is turned on but I don't want to sit around watching TV all day. I don't go out much because I can't afford to. Sometimes I take pills from the chemist just to stop the boredom.'

I heard similar stories from other people living in boarding houses – of being forced to work for no money, of chronic boredom, lack of privacy, stolen possessions, sexual abuse, foul food and flea-infested rooms. Most of them agreed that boarding houses were even worse than being in hospital. (O'Hagan, 2014, p 156)

Legislative abuse

42. Legislative abuse includes the use of legal coercion, particularly beyond the scope of the law.
43. Survivors talked extensively about being forcibly placed in psychiatric hospitals. While many were subject to mental health legislation, others were subjected to coercive practices despite their voluntary status. Forced detention and treatment were often

experienced as torture, traumatising, inhuman, degrading and cruel. Survivors on admission were often stripped, bathed without privacy and had their clothes taken away and forced into solitary confinement. (Gallen, 2001; Henwood, 2015; Mahony et al, 2007).

44. When I interviewed Veronica, she had recently been sectioned:

Two policemen came and picked me up because I wouldn't let anyone into the house. I think I was quite within my rights not to have anyone in the house. I was forced to go with them and the actual examination of me was a complete and utter farce. I was put in the prison cells for one night. I'm not complaining about the fact I wasn't well but the method – I had no advocacy, I was entirely defenceless. Two young doctors came and wrote busily about me in my cell. They said hardly a thing to me. They didn't ask me any questions. They hardly said a thing to the judge and on those grounds I was committed. (O'Hagan, 2014, p 142)

45. Māori with lived experience, who are more likely to be sectioned than non-Māori, have also talked about the violations they experienced under the Mental Health Act:

I ... have [been] degraded by people in positions of authority who are funded by the taxpaying Government to serve and protect us – not abuse and mistreat those in the community who are treated worse than dogs under the mask of New Zealand's Mental Health Act ... I felt ashamed and fearful. My mental state of mind further deteriorated due to their response. I felt traumatised and felt that my basic human rights as a woman had been blatantly violated. (Story provided through personal communication with authors Dr Lynne Russell, Dr Michelle Levy and Lisa Cherrington).

Treatment abuse

46. Treatment abuse includes psychiatric remedies that are forced and cause harm.
47. Psychotropic drugs and electroconvulsive therapy (ECT) were the most common treatments in the 1950-1999 period. Other treatments, such as group therapy, deep sleep therapy, aversion therapy and abreaction therapy were also used in some services. In the early part of the period insulin shock therapy and lobotomies were also used. The first-generation antipsychotics, used from the 1950s to the 2000s, also caused tardive dyskinesia, permanent involuntary movements that included grimacing, sticking out the tongue, or smacking the lips. The hospitals prescribed Paraldehyde until the 1970s, despite its potential to cause convulsions, hallucinations and respiratory disorder.

Psychotropic drugs

48. Survivors who spoke to the Confidential Forum and the Confidential Listening and Assistance Service described the use of strong drugs, high doses, and polypharmacy. Survivors rarely gave informed consent. Medications were sometimes given to sedate and control, rather than to produce therapeutic benefit. Some survivors reported the

administration of Paraldehyde and other medications as punishment. Many survivors, as well as their family members, reported that mental health deteriorated significantly as a result of treatment. (Henwood, 2015; Mahony et al, 2017).

49. The over-use of medications severely affected people's ability to function. Survivors recalled being unable to stay awake, to walk, to talk or undertake personal care. Many also experienced blurred vision, impaired memory, tremor, dribbling, insomnia and extreme weight gain. While staff often minimised the adverse effects of psychotropic drugs, survivors described them as significant and long-lasting. Family members echoed survivors' reports of heavy use of medications, frequent changes of medication, severe adverse impacts and the significant deterioration of their relative over time. (Henwood, 2015; Mahony et al 2007).
50. Anne Helm wrote about her experience of deep-sleep therapy at Cherry Farm Hospital in the 1970s:

I was placed on a six-week deep-sleep programme where the main concern was the constant taking of blood pressure because the huge amounts of medication coursing through my body could potentially paralyse and stop fundamental functioning. At the end of this 'treatment', my legs atrophied from complete bed rest, I could not support my bloated weight ... I was barely able to lift my head from a pillow. (Peterson and Gordon, 2009, p 192).

51. Egan Bidois spoke about his experience of medication at Tokanui Hospital in 1990:

At the highest point of my medication regime I was on four different anti-psychotics and three sedatives – over the maximum dosages for all of them. I gained 40 kilograms in the space of about four months. I was effectively a ... zombie. (Bidois, 2019)

Electro-convulsive therapy (ECT)

52. Psychiatric hospitals routinely administered unmodified ECT until the mid-1950s when modified ECT, using anaesthetics and muscle relaxants, became recommended practice. However, Sir Rodney Gallen's Report on Lake Alice psychiatric hospital provides clear evidence of the use of unmodified ECT through the 1970s. It also documents the use of ECT as punishment, administered on children and young people's body parts. He described these ECT practices as 'a regime of terror' and reported them to the United Nations Committee on the Convention Against Torture.⁴ (Gallen, 2001)
53. ECT survivors reported to the Confidential Forum that the process of ECT was terrifying. It caused significant memory loss and some mothers said they were unable to remember their children (Mahony et al, 2017).⁵

⁴ https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=222791;

<http://newzealandchildabuse.com/malcolms-story/>

⁵ <http://www.stuff.co.nz/ipad-big-picture/6211507/Electroconvulsive-therapy-endures>

54. Egan Bidois talked about his experience of ECT as torture:

I received 27 courses of ECT – 27 times being carried off, strapped down to a table and having the national grid pumped through my skull. I distinctly remember being strapped down and have one of the orderlies lean over me and abuse me and tell me unless I play the game they will keep doing this. They basically fried me until my head was smashing against the table. That wasn't treatment for me. It was torture. (Bidois, 2019).

Psychological abuse

55. Psychological abuse includes bullying, threats, cruelty and put-downs.
56. The Confidential Forum and the Confidential Listening and Assistance Service reported that survivors talked about many kinds of psychological abuses by staff (Mahony et al, 2007; Henwood, 2015). This included demeaning jokes, emotional abuse and cruelty.
57. Janet Frame wrote a fictionalised account of her experiences in psychiatric hospitals in the 1940s and 50s, in which she gave a graphic account of staff cruelty:

I was ... horrified to see that, at times, the nurses tried to provoke the patients into displays of violence. They did this with Helen who walked stiffly like a tin soldier, holding her arms out as if to embrace anyone who came her way, and whispering, 'Love, Love' ...

'Love me, Helen,' the nurse would call, and Helen, smiling with anticipated joy, would advance carefully towards the nurse only to be turned aside with a scornful remark when her arms almost encircled their longed-for objective of flesh. Her love changed to hate then; she would attack, and the nurse would blow her whistle bringing the other nurses to her aid, and Helen would be put in a strait jacket for the rest of the day. (Frame, 1980, pp 90-91)

Physical abuse

58. Physical abuse includes hitting and physically forcing people.
59. According to the Confidential Forum survivors recalled many kinds of physical abuses by staff, such as being punched, thrown on the floor, pushed up against a wall or being given unmodified ECT. The institutional milieu was punctuated with screaming and yelling, physical violence and manhandling people into ECT or solitary confinement. (Mahony et al, 2007)
60. In the 1980s I interviewed Gerald about his time in Oakley Hospital:

Oh sure, I've been beaten up by staff. At the secure hospital there was a rule you had to strip naked in the corridor, leave your clothes out, go into your room totally naked, and get your pyjamas on and go to bed. I found that really hard to do because of my physical disability so I took my clothes off in my room. I had three buttons undone on my shirt and they literally ripped my

clothes right off me, pants and all, testicles squashed. It was standard practice. (O'Hagan, 2014, p 140)

61. In my memoir, I quoted from a report by a researcher called Vince who interviewed nurses about the Psychiatric Survivors advocacy service at Carrington Hospital. An extract of Vince's conversation with Nurse 7 follows:

Vince: How much do the staff talk to the patients?

Nurse 7: When I first got here I was told not to talk to the patients. But sometimes I feel sorry for them. Sometimes a patient will talk to me about their problems but I know the nurses will be angry if they hear me ...

Vince: What about hitting?

Nurse 7: Yeah, even though I smack them now and again, I've seen some staff really hit them. I say to myself if I see it again I'll report it, but I don't want to be a troublemaker or a stirrer. I don't want to get involved with that. I like it here. Everything is all right here. (O'Hagan, 2014, p 175)

Sexual abuse

62. Sexual abuse includes non-consensual sexual contact or harassment.
63. The Confidential Forum and the Confidential Listening and Assistance Service both reported that survivors talked about sexual abuse by staff, including rape. Survivors also reported sexual and physical abuse by other residents within the context of high levels of distress, and unsafe, mixed age and mixed gender facilities. (Mahony et al, 2007; Henwood, 2015).
64. Debbie Peterson wrote about her experience of sexual abuse in the 1990s:

During one hospital admission when I was 26...I was sexually abused by a male nurse. I reported it and eventually the police were called. I was taken to the police station, gave my statement and returned to the ward. Naively, I thought I'd be okay there. Instead I was put in the same seclusion room the incident happened in, told I wasn't to talk to anyone, and was 'looked after' by some very angry nurses. It was apparent they didn't believe me ... I was terrified. (Peterson and Gordon, p 203).

65. Sexual abuse was not just confined to hospitals. Steve talked to me about his experiences in a previous boarding house in the 1980s:

The manager at one of [the boarding houses] sexually harassed me. He used to call out to me at night to come to his room. It was really bad. I was quite sick at the time and didn't know what I was doing. (O'Hagan, 2014, p 156).

Cultural abuse

66. Cultural abuse includes colonisation, racism and denial of access to cultural worldviews and supports.
67. The Wai 2575 report on Māori health inequities states that colonisation in the form of assimilationist policies and practices and institutional racism have marginalised Māori knowledge systems, ways of knowing and values. Māori experiences of psychiatric abuse are compounded by the impact of colonisation and alienation from whenua, whakapapa, and whānau, which are the key ingredients for wellbeing (Cram et al, 2019). The Confidential Forum reported that Māori survivors experienced a violation of their cultural values, beliefs and experiences within the mental health system; their experiences were routinely pathologized and this caused significant harm (Mahony et al, 2007).
68. Māori submitters to the Government Inquiry into Mental Health and Addiction (2018) made it clear that to this day mental health and addiction services are agents of colonisation:

At the heart of current Māori 'un-wellness' is colonisation, institutionalised racism, unconscious bias and a western model of wellbeing, with systems that strengthen that model and perpetuate further inequity than those already experienced by Māori. (p 42)

69. Egan Bidois has seen and heard things that other people can't since he was three years old. His family accepted this but when Egan's voices and visions became overwhelming, he was admitted to Tokanui Hospital in 1990:

In the hospital notes they wrote about me: 'Patient in room staring blankly against wall and was muttering incomprehensible word salad and gibberish and was asked to keep quiet'. But I was saying karakia to calm myself and seek protection and safety. Their method of asking me to keep quiet was to come into my room, grab me by my long hair, pull my head back and scream in my face – 'Shut up nigger'. (Bidois, 2019).

70. Egan Bidois also talked about another occasion where the staff wrote of him:

'Patient was out in the yard, screaming, gesticulating, yelling violent obscenities and punching at the air'. But Egan was doing the haka to help him release his excess energy. For that he was locked in seclusion for three days (Bidois, 2009).

71. Sarah Pokoati, a young Pasifika woman talked about racism in hospital in the 1990s:

When I was in hospital I found all the Pākehā nurses used to treat their race better. We were looked at like underdogs. Like they always got their dinner served first. They got special privileges. Us Islanders didn't. We were just

chucked in there, had breakfast, lunch and tea and that's about all. (Leibrich, 1999, p 27).

Property abuse

72. Property abuse includes withholding or stealing money or goods.
73. The hospital admission process usually involved the removal of clothing and other personal property. Survivors did not always have their own clothes or have free access to their money. Many smoked cigarettes and staff controlled access to them as part of a reward and punishment regime. In the 1970s and 80s, in what became known as the Interest Scandal, the hospitals kept the interest money from individuals' welfare benefit payments that were paid into hospital trust accounts. The practice was stopped in 1987 when the Department of Health was advised that withholding interest money from the welfare benefit claimants was probably illegal.
74. I wrote about the removal of my property during my first admission to hospital in the late 1970s:

Chantelle walks me down a long polished corridor into a pale pink room with a steel bed and a chipped, wooden bedside cabinet. She hands me a white surgical nightie with a back that doesn't do up. Then she picks up her clipboard and asks me some questions, but I have no reason to answer them.

'How about getting into bed?' she asks.

She packs all my possessions into a brown paper bag.

'My things,' I mumble.

'I'm just going to lock them in the property room for safe keeping.'

'But—.'

Chantelle has already left the room. (O'Hagan, 2014, p 50)

Narrative abuse

75. Narrative abuse includes prognoses of doom and a focus on people's deficits.
76. Survivors who spoke at the Confidential Forum and the Confidential listening and Assistance Service, recalled how staff often viewed them with a deficit lens and gave them a bleak narrative about their future. This involved being told that they would not get out of hospital, would be medicated for life, would not be able to study, work or live independently, and should not have children. These narratives led to hopelessness and contributed to negative consequences across all spheres of survivors' lives (Henwood, 2015; Mahony et al, 2007).
77. Egan Bidois recalled the psychiatrists' conversation with his parents:

They had this conversation with my parents. They didn't want my parents to constantly visit me seeing me become more and more unwell. I remember the doctor saying, "Your son, Egan, is not coming home. He has one of the worst cases of paranoid schizophrenia we have ever encountered. There is absolutely no form of treatment that can bring him back. I remember the look in my parents' eyes. It was the look of someone's hope dying. (Bidois, 2019)

78. I wrote about the prognosis of doom given to me by my psychiatrist:

Dr Pilling is standing at his desk sorting through a large untidy stack of files. He sits down, opens my file and his face turns serious. 'I think it's timely for me to tell you about the impact your illness is likely to have on you. You have a chronic condition which will recur for the rest of your life.'

'Do I really?'

'The medication can help but you need to reduce stress and lower your horizons. A big career or full-time work probably aren't options, I'm afraid. And you need to think very carefully about having children, in case they inherit your illness.'

'Does anyone recover?' I ask.

'Not usually,' he says. 'I'll see you next week'. He looks up and smiles then starts writing his notes as I close the door behind me.

My eyes fill with tears. (Peterson and Gordon, 2009, pp 46-47)

Impact of abuse

79. The Confidential Forum and the Confidential Listening and Assistance Service reported on the ongoing impact of abuse on survivors including trauma, poor health and life outcomes and broken whānau and community connections. The impact on Māori was particularly damaging. (Henwood, 2015; Mahony et al, 2007).

Ongoing trauma

80. Survivors reported that they continued to experience life-long psychological distress. They recalled living with low self-esteem, frightening memories, frequent nightmares, hypervigilance, shame, grief, sadness and loss, anger and rage because of abuse within services. Many described their overwhelming struggle to make sense of multiple abuses. (Henwood, 2015; Mahony et al, 2007).
81. Survivors suffered losses in many areas of life. They lost connection to whakapapa, whānau, and whenua (Cram et al, 2019). For many survivors, the damage to identity, the loss of human status and the violation of human rights permanently damaged their roles and status as citizens (Mahony et al, 2007).

82. I interviewed around thirty survivors in the 1980s. I concluded that:

Many had never talked about their experience in one sitting before, to someone who took them at their word. Some cried as they talked about all the pain they had endured. So much of it was not due to the experience of madness itself but about their experiences in hospital, their lost opportunities, about once promising young lives that had fallen into unemployment, poverty and loneliness. They talked again and again of hospital staff who took their dignity away or never talked to them, the overuse of drugs, of seclusion, the trauma of compulsory treatment, the lack of psychotherapy and support, and the lack of information about drugs and side-effects. So much of their suffering could have been avoided if the mental health system and the rest of society had genuinely responded to them. (O'Hagan, 2014, p 146)

83. Anne Helm wrote about her trauma that went unattended:

Denial of experience also deeply buried the etched traumatic memories of some institutional experiences and invalidated healthy reactions of natural grief and anger. Earlier losses – the death of my mother, the loss of a singing career, the removal of my first-born daughter to others' care – lay unattended. No-one had deemed these events important enough to support me to talk about them. (Peterson and Gordon, p 193)

Poor life and health outcomes

84. Many survivors talked about the trauma from abuse leading to addictions, self-harm, suicidality and physical health conditions. Some died prematurely, while others died by suicide. Many survivors lived in poverty and had lost opportunities for education, secure employment and stable housing. (Mahony et al, 2007; Henwood, 2015). Many relied on income support or ACC and had to deal with Work and Income or ACC staff whose processes often mirrored the abuse in mental health system – of being monitored, misjudged and incorrectly written about after sharing intimate details of their lives. (Mahony et al, 2007).
85. I wrote about Elizabeth, a long-term patient at Carrington Hospital in the 1980s who died of neglect:

Elizabeth had a minor learning disability and a major sense of injustice about how the hospital had treated her since she was admitted a quarter of a century before. She was in her sixties, thin and scrawny, and she talked incessantly between shallow puffs of her cigarettes about how she should never have been admitted to the hospital in the first place. She paced a lot and her tongue rolled uncontrollably, the legacy of years of anti-psychotics. 'I can't get out. My family don't want me back. They put me in here, you know. Don't even visit me. Please tell boss nurse I don't feel well. They don't listen to me. Had a pain in my gut for months.' We agreed to talk to boss nurse and reassured Elizabeth she was not the only patient the staff didn't listen to ... It turned out that Elizabeth had terminal bowel cancer. She died a few months

later. (O'Hagan, 2014, pp 176-77)

86. Anne Helm was lucky enough to leave the institutions behind her but faced the difficult task of re-creating herself with a diminished sense of personal power:

Creating oneself in a post-institutional world seemed to be more a hit-and-miss game of random chance. A legacy from institutional life was that I had little power to change personal outcomes. Most of my young adult life had been decided for me and believing I had the ability to change my destiny remained difficult. Finding a sense of place in the wider community seemed to be determined, not by how one played, but by other players. Being more than 'the crazy one' was a work of re-creation. (Peterson and Gordon, p 193)

Broken whānau and community connections

87. The stigma of being admitted to a psychiatric hospital coupled with routine medical advice of the time often meant long-term separation from families and whānau. Most whānau visited infrequently or stayed away. For some survivors, disconnection from families and whānau resulted in a life-long sense of abandonment and feeling of not belonging. Sometimes ashamed families and whānau avoided contact with survivors or constructed narratives about survivors that were themselves abusive. Many survivors described their struggle in trusting others, developing and maintaining relationships, and sustaining a sense of connection. (Mahony et al, 2007; Henwood, 2015)

88. Veronica shared her losses and broken connections with me in the 1980s:

I was a teacher until ten years ago but I don't know if I could get a job again after being a committed patient. I'd probably have to lie about myself. I'd like more status in the community. The drugs and stresses in our lives tend to make psych patients unassertive. To be in a job where I had to be assertive would be very hard – I don't think I could do it.

I feel close to tears when I think of the effect my manic depression has had on my life and my child's. I've lost self-esteem, confidence – yes, tremendous loss of hope, loss of power and loss of respect from everybody. I lost all my friends and never regained their trust and respect. I've written my family off. I haven't received any real lasting help from anywhere. (O'Hagan, 2014, p143)

89. Anne Helm wrote about her loss of place in her family of origin:

Like many others from the era of institutionalisation, I have an enduring struggle to be accorded familial respect and honour as a member of my family of origin. Acknowledgement of the severe stressors, profound loss and trauma as being significant contributors to my 'break down' was never given by my family. (Peterson and Gordon, 2009, p 191).

Impact on Māori

90. The Confidential Forum and the Confidential Listening and Assistance Service included disproportionately high numbers of Māori survivors. However, neither reports specified the impact of abuse on Māori. A recent report on Māori health inequities highlights the overarching abuse of Māori in the context of a broader colonial health system. Māori not only experience disproportionate abuse in psychiatry, but the impacts are cumulative in the context of other colonising forces (Cram et al, 2019).
91. Māori submitters to the Government Inquiry into Mental Health and Addiction (2018) made it clear that colonisation, including the medical model and way distress is conceptualised in psychiatry, contribute to intergenerational trauma. The big focus on symptoms, diagnosis and medical treatments is not grounded in evidence about what works for Māori and fails to address the processes of colonisation that are at the root of much distress for Maori.

92. A Kaimahi Māori told the Government Inquiry into Mental Health and Addiction:

Whānau are fearful of our Ministries. Fearful of mental health. Fearful of Oranga Tamariki taking their children. Fearful of Police who take away their Dads. Whānau are on the back foot before anything that happened, just because they are Māori. (p 33)

93. Whanaunga of a person with lived experience talked about the corrosive impact of colonisation and alien systems on Maori:

These alien systems denied (and still do) the harm that had been wrought in the collective body, mind and heart of Māoridom, while at the same time demonising Māori people and culture for the outcome of these harms. Alongside widespread economic, physical and spiritual deprivations from the erasure [of] the conditions necessary for life, and also our spiritual and wellbeing institutions and practitioners, systemic denigration of Māori began to carve into my grandfather and grandmother's hearts and minds the notion of their inherent inferiority and fated impairment. They began to despise themselves and all things Māori as they internalised and acted out colonially-induced systemic self-hate ... the echoes of this hate infestation continue to resound through our personal and collective hearts and minds. (Story provided by personal communication with Dr Lynne Russell, Dr Michelle Levy and Lisa Cherrington)

Mental health services after 1999

94. The closure of the large hospitals was followed by the growth of community based clinical and support services in the late 1990s and early 2000s. Community support services provided a broader range of responses than the clinical services, such as housing, employment support, system navigation and support with day-to-day living.

However, current mental health legislation, the dominance of clinical approaches and institutionalisation remain at the hub of the mental health system.

The dominance of clinical approaches

95. The mental health system remains a strongly medicalised one focused on the use of medication, the Mental Health Act and locked inpatient units. Seventy-five percent of specialist mental health and addiction funding still supports clinical services. They are primarily staffed by medical and allied professionals. Psychiatrists have decision making authority, make treatment decisions that cohere around medication regimes and often have little contact with people using services (Barnett and Barnes, 2010). People detained in inpatient units rarely access indigenous healing approaches that do not involve drugs (personal communication with Dr Lynne Russell, Dr Michelle Levy and Lisa Cherrington).
96. Many continue to report high doses of medication, often multiple medications at once, causing a range of adverse effects (Balance Aotearoa, 2018; Government Inquiry into Mental Health and Addiction, 2018). The Mental Health Commissioner has drawn attention to the absence of data about prescribing practices in mental health units (Mental Health Commissioner, 2018). Anti-psychotics cause weight gain, metabolic syndrome, diabetes, cardiovascular disease and early death (Te Pou o te Whakaaro Nui, 2017). They continue to be used as a mainstay treatment in high doses and are the main drug of choice for compulsory treatment.

Continuing institutionalisation

97. Institutionalisation during the 1950-1999 period was represented in large buildings separated from local communities. Small institutions in the form of mental health units are now located within general hospitals. People subject to the Mental Health Act can be detained in acute inpatient units for months at a time (Mental Health Foundation, 2016). There is also an expanding network of forensic institutions throughout New Zealand where people can be incarcerated for many years (Ministry of Health, 2019).
98. Although the large institutions no longer exist, the ongoing interface of mental health legislation and clinical dominance has influenced some community approaches to service provision, such as medication runs, supervised accommodation and community treatment orders. This has created a hospital without walls; a new form of institutionalisation that is described as institutionalisation of the mind. (Chow and Priebe, 2013).

Rising rates of compulsory treatment

99. The Mental Health (Compulsory Assessment and Treatment) Act 1992 introduced community treatment orders and the right to seek a review of one's committed status. Despite the right to a review, community treatment orders have led to rising rates of compulsory treatment, not seen in New Zealand since they peaked in the 1950s (Ministry of Health, 2006). In 2017, 10,286 people were sectioned under the Mental Health Act and Māori were 3.5 times more likely to be sectioned than non-Māori (Ministry of Health, 2019). People can be placed on a community treatment

order indefinitely. New Zealand's community treatment order rates are very high by international standards (Mental Health Foundation, 2016).

100. Many submitters to the Government Inquiry into Mental Health and Addiction (2018) spoke of their experiences of compulsory detention, often for long periods of time, being forcibly treated and being denied the right to self-determination and participation in decisions about treatment. They also described the trauma associated with compulsion, the adverse impacts of forced medications, and the harm caused by solitary confinement.

Throughout this Inquiry, many people shared their experiences of being held and compulsorily treated under mental health legislation ... [and] prolonged use of the Mental Health Act. Many submitters across the country emphasised the need for New Zealand legislation – and the practices enabled under it – to comply with international and domestic human rights instruments. (p 189).

Changes to stop abuse

101. Since 1999 some developments have attempted to counter or prevent abuse in mental health services. At the international level, these developments include the UN Convention on the Rights of Persons with Disabilities and the UN Declaration on the Rights of Indigenous People. At the national level we have seen programmes to reduce seclusion and restraint, review and complaints processes, several inquiries and a process to apologise and compensate people who have experienced abuse in mental health services. However, twenty years on, abuse in mental health services continues, despite the closure of the long-stay institutions, rhetoric about recovery and developments in human rights' protections.

UN Convention on the Rights of Persons with Disabilities

102. The UN Convention on the Rights of Persons with Disabilities (United Nations General Assembly, 2006) states that persons with disabilities (including people with mental distress) are equal before the law and should not be deprived of their liberty because of their disability. As a result, much of the commentary coming from the United Nations is critical of mental health legislation. For instance, the Special Rapporteur for the Disabilities Convention has made it clear that mental health legislation that permits discrimination, forced treatment, substituted decision making, and 'the best interest' standard must be repealed:

[As] long as mental health laws allow for the involuntary deprivation of liberty, forced treatment and forced medication of person with disabilities, those laws are contrary to the Convention (United Nations General Assembly, 2017, p 12).

103. Member states, including New Zealand, appear to be in denial about the full implications of the Convention; they respond to the Convention by seeking reform, rather than repeal.

The UN Declaration on the Rights of Indigenous Peoples

104. The UN Declaration on the Rights of Indigenous Peoples (United Nations General Assembly, 2007) specifically recognises the right to recognition, observance and enforcement of treaties and agreements with states, such as Te Tiriti o Waitangi. It recognises the importance of indigenous peoples' rights to life, physical and mental integrity; the right to liberty and security of person; the collective right to live in freedom and peace; the right not to be subject to forcible removal of children to another group; and the right not to be forcibly removed from lands. The Declaration draws specific attention to the rights of indigenous disabled people, equal access to justice, and the importance of free, prior and informed consent (United Nations General Assembly, 2019, p4).

Inquiries, compensation and apologies

105. The Gallen Report resulted in an apology and monetary compensation to over 90 complainants who had experienced abuse as patients in Lake Alice Hospital in the 1970s.
106. The Lake Alice settlement helped to build pressure for the government to provide a more overarching response to abuses in mental health services.
107. The Confidential Forum for Former In-Patients of Psychiatric Hospitals was established in 2004 but its terms of reference were kept narrow to avoid Crown liability; it was set up to provide a confidential environment for people to talk about their experiences, to support them to find counselling and other assistance services, and to report on the numbers of participants, the services they were referred to and the usefulness of the process to participants. While the report, *Te Āiotanga*, stretched the boundaries of the Terms of Reference by giving a thematic summary of people's experiences, there was no substantive response from the government towards a formal apology or compensation for survivors.
108. The Residual Health Management Unit (later renamed the Crown Health Financing Agency) was formed in 1993 to manage the residual public health system assets and liabilities that could not be transferred to the new Crown Health Enterprises, among them claims associated with historical abuse and neglect in psychiatric hospitals. By 2011 CHFA had received 336 psychiatric patient claims. CHFA developed a settlement strategy in consultation with the plaintiffs' lawyers and in 2012 made offers to the plaintiffs that included a modest 'wellness' payment, payment of legal costs related to the complaint and a letter of apology. All but seven of the plaintiffs accepted. (Personal communication with Graeme Bell, former CEO of CHFA).

Review and complaints mechanisms

109. There are currently three key mechanisms available to people who use mental health services to make a complaint about abuse or seek review of their status under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
110. People subject to the Mental Health Act can seek review through the Family Court or the Mental Health Review Tribunal. There is strong evidence that these processes to

protect human rights and prevent mental health system abuse do not work well (Gordon and O'Brien, 2014; Mental Health Foundation, 2016). For instance, in 2017 the Mental Health Review Tribunal heard 62 applications for release from the Mental Health Act. Of those applications only six people were released. (Ministry of Health, 2019).

111. People who use Mental Health services, including those who are subject to the Mental Health Act, can make complaints to the Health and Disability Commission, if complaints to the service itself have not yielded a full response or resolution. However, these complaints processes often advantage a powerful medico-legal system that has more resources, clout and knowledge than the people making the complaint. (Gordon and O'Brien, 2014; Mental Health Foundation, 2016).

Eliminating seclusion and restraint

112. The Mental Health Commission published a paper in 2004 that argued for the reduction and elimination of seclusion in mental health services (Mental Health Commission, 2004). Official moves to reduce and eliminate seclusion were started by Te Pou o Whakaaro Nui over a decade ago (O'Hagan, Divis and Long, 2008) and continue with the Health Quality and Safety Commission's project to achieve zero seclusion by 2020.
113. Despite some successes, the Mental Health Commissioner has recently highlighted a high rate of seclusion for Māori and noted that although the overall seclusion rate has decreased 30% since 2007, the seclusion rate for Māori has only decreased by nine per cent. In 2016, 102 young people aged 19 or less were secluded. There remains wide variation in the use of seclusion and restraint across District Health Boards (Mental Health Commissioner, 2018). Seclusion rooms continue to be built in new mental health facilities in 2019.⁶

Advance directives

114. People have a right under the Code of Health and Disability Services Consumers Rights⁷ to use an advance directive to make their wishes known about the treatments and care they receive during a future episode where they lose competence. However, advance directives are rarely used in mental health and there has been some clinical resistance to them.

E Kore Anō – Never Again

115. Abuse in mental health services will continue until most if not all institutions are replaced by community based responses, there is an end to special mental health legislation for people with 'mental illness' and psychiatry is replaced at the hub of the system by communities who control the narrative and the resources, including Māori,

⁶ Radio New Zealand <https://www.rnz.co.nz/national/programmes/checkpoint/audio/2018673943/inside-new-zealand-s-newest-seclusion-rooms> (accessed 12 09 19)

⁷ <https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/>

Pasifika and people with lived experience of distress. At the same time, we need to continue work to reduce stigma and discrimination in the wider community.

Redress and rehabilitation

116. The process of redress and rehabilitation for people abused in mental health services has not got off to a good start in Aotearoa New Zealand. The report of the Confidential Forum did not lead to redress and rehabilitation, there has been little public acknowledgement and the settlement process with affected individuals has not been completed. The Royal Commission provides an opportunity to establish a more deliberate and comprehensive redress and rehabilitation process. Survivors need to lead decision making about this process.

Establishing a good process

117. Recommendations from international inquiries into abuse include:

- The aim must be to fully recognise and enable healing across all spheres of survivors' lives.
 - Claims need to be assessed against national and international human rights frameworks.
 - The state must ensure that the process and people leading it are independent from government and organisations that have perpetrated abuse.
 - The process needs to be administered by people who have a sophisticated understanding of human rights, abuse and trauma.
 - The system needs to be straight-forward and prompt.
- (Personal communication with Dr Heather Barnett).

Apology

118. Survivors of psychiatric abuse have called for two public apologies. One from the state and one from the Royal Australian and New Zealand College of Psychiatrists. Survivors need a 'complete apology' which includes:

- An acknowledgement of a wrong committed, including the harm it caused.
- An acceptance of responsibility for having committed the wrong.
- An expression of regret or remorse both for the harm and for having committed the wrong.
- A commitment, explicit or implicit, to reparation.
- A commitment to non-repetition of the wrong (Diesfield, 2012:56).

119. The process leading to apology, especially for survivors of abuse in mental health services, needs to affirm the reality of their experiences, which have often been routinely denied. The apology also needs to acknowledge survivors who have died and to extend the apology to their families and whānau.

120. Survivors have called for a belated public acknowledgement of the report of the Confidential Forum published in 2007. They are seeking acknowledgement of *Te Āiotanga* at the start of the Royal Commission of Inquiry's report and identification of how the voices of people who participated in the Confidential Forum have been

included in the Royal Commissions processes and recommendations. They also want the report to be widely disseminated to all New Zealand public libraries, all university libraries, the National Library and New Zealand Archives and to be available via the Ministry of Health and Department of Internal Affairs websites. (Personal communication with Anne Helm).

Monetary redress

121. Monetary redress needs to involve consideration of five key factors:

- Survivors' interests.
- Realistic costs given by the state.
- Transparency of processes.
- Ongoing support for survivors.
- Justice being served to survivors.

(Winter, 2018).

122. Māori need to be additionally compensated for the impacts of colonisation and systemic racism perpetrated by the state through mental health services (Cram et al, 2019).

123. It is important that all redress and rehabilitation funding provided to survivors is free from asset testing and taxation. This means that funding will need to be exempt from all Work and Income and ACC entitlements and from any other asset tested funding, in perpetuity.

124. Psychiatric survivors die up to 25 years earlier and have poorer physical health outcomes than the rest of the population (Mental Health Commissioner, 2018). Māori also have a shorter life expectancy and poorer physical health outcomes than non-Māori (Cram et al, 2019). To ensure an equitable system, an advance payment scheme will be needed. The Scottish Child Abuse Inquiry has provided for advance funding to older and unwell survivors of abuse.⁸

Funding for healing

125. Funding for healing needs to be part of the broader package of redress and rehabilitation for survivors – either as a lump sum or ongoing payments. It should be available for as long as an individual survivor feels it is necessary. The nature of approved healing approaches needs to be broadly defined. This may include access to kaupapa Māori supports, reconnection to whānau, hapū and iwi, alcohol and drug counselling, psychotherapy, sexual abuse counselling services, peer support services, participation in creative arts or meditation.

126. Survivors applying for ACC counselling should be defined within ACC legislation as a distinct group of people with complex trauma. This would entitle survivors to access

⁸ <https://www.drummondmillar.co.uk/news/2019/05/compensation-for-survivors-of-historic-child-abuse-what-the-scottish-governments-advance-payment-scheme-is-and-what-it-means/>

therapy without the requirement to go through an ACC diagnostic assessment by psychiatrists, which could be re-traumatising for them.

Clean slate policy

127. Survivors have spoken of the link between abuse in mental health services and entering the criminal justice system. The legacy of a life in institutions – mental health and penal – is one of stigma and discrimination. A qualified clean slate policy would be a powerful mechanism to assist survivors' healing and opportunities for the future. Examples for people in the criminal justice system include:

- A clean slate policy for prisoners in New Zealand:
<https://www.rnz.co.nz/news/national/370300/former-prisoners-want-in-on-clean-slate-after-seven-years>
- The Australian 'spent convictions' scheme:
<https://www.afp.gov.au/what-we-do/services/criminal-records/spent-convictions-scheme>
- The Canadian 'record suspension' scheme:
<https://www.canada.ca/en/parole-board/services/record-suspensions.html>

Other remedies

128. Other jurisdictions have proposed a diverse range of redress and rehabilitation schemes for different groups that have been harmed by the state. Examples include:

- A national memorial to publicly acknowledge people who were abused in state care:
<http://monumentaustralia.org.au/themes/culture/indigenous/display/110952-stolen-generations-memorial>
- A national approach to remembering the people who died in psychiatric hospitals and were buried in unmarked graves:
<https://www.stuff.co.nz/national/76590650/memorial-unveiling-set-at-tokanui-cemetery-to-honour-former-psychiatric-hospital-patients>
- Compulsory education about state abuse as part of the national school curriculum at primary and secondary levels, such as the Chicago Police torture of black men:
<https://www.theguardian.com/news/2019/mar/08/chicago-reparations-won-police-torture-school-curriculum>
- NGO education programmes, such as the stolen generations in Australia:
<https://australianstogether.org.au/about-us/>
- Guaranteed access to university or tertiary education, placement in a programme of choice, and payment of fees, costs and living expenses for this purpose:
<https://www.theguardian.com/uk-news/2019/jul/25/scotlands-universities-offer-guaranteed-places-students-in-care>
- Free access for survivors to numeracy and literacy education.
- Free access for survivors to primary health services.

Conclusion

129. The road to the Royal Commission is lined all the way back to the 1840s with the casualties of abuse in mental health services. Governments, communities and mental health services have yet to fully reckon with this abuse. They must acknowledge the harm done, to provide redress and rehabilitation and make systemic reforms that end institutionalisation, the dominance of psychiatry and compulsory interventions as well as resolve the impacts of colonisation. The Royal Commission is our overdue opportunity for New Zealand to draw a line in the sand and to say e kore anō – never again.

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