MARY ANNE O'HAGAN - AFFIRMED

EXAMINED BY MS JANES

(Via telephone)

Q. Hello, Mary, can you hear me?

A. Hello.

Q. Hello. Have you got your brief of evidence with you that you prepared for the Royal Commission?

A. Yes, I do.

Q. Can you state your full name for the record?

A. Yes, my full name is Mary Anne O'Hagan.

CHAIR: Mary, it's Anand Satyanand speaking. Can I, in order to comply with the Inquiries Act, first of all obtain an affirmation from you? (Witness affirmed).

MS JANES:

Q. Mary, can you provide some background information to the Commission about what has led you to give expert evidence today?

A. Yes. Well, I initially came into the area because I was a user of Mental Health Services for a number of years in my 20s and I was a prolonged patient of the hospital and I was given a pessimistic prognosis about my future which was totally wrong.

But after I came out of that experience, I was one of the initiators of the Psychiatric Survivor Movement in New Zealand. Then I went on to become the first Chair of the World Network of Users and Survivors of Psychiatry and through that role I became an advisor to the WHO in the United Nations and also had a hand in the United Nations Convention on the Rights of Persons with Disabilities. That was while I was a Commissioner,

New Zealand Mental Health Commissioner, I held that role for 6.5 years. Since then, I've run a social enterprise and I've now just taken on a role as programme lead for the Like Minds, Like Mine programme to uphold the mana and human rights of people with mental distress.

I want to say, in some of the publicity it says I am an abuse survivor. I've never called myself an abuse survivor. But I have witnessed abuse, I have heard stories of abuse and I have, you know, researched about
14.49 abuse and so on, so I'm very familiar with the whole territory.

Q. Thank you. And in your introduction, you've talked about your view of abuse and whether it's widespread in Mental Health Services and whether there are some good aspects. Do you want to just briefly comment on that?

A. Yes. So, yes, I believe that abuse is widespread and continues to be widespread. I think it changes its spots over time. But, on the other hand, I think we - I want to acknowledge that, you know, people who have been
14.50 abused, they have had experience of compassion and kindness and some people say they have benefitted from Mental Health Services. But this doesn't take away the gravity of the abuse that has gone on.

Q. And when you talk about mental health or mental illness, what perspective do you use that term from?

A. Well, the concept of mental illness is used in - it comes from western medicine and really it's only been around for 200 years and it didn't exist in traditional Maori society, and I think it's really important to acknowledge
14.51 that. And it was really, you know, the idea of mental illness as a whole sort of psychiatric apparatus was imported as part of the colonial infrastructure of New Zealand. And I just want to add that, this psychiatric apparatus or structure, from the 1840s on was

an institutional environment. In New Zealand psychiatric hospital numbers peaked in 1944, so they stopped planning for new psychiatric hospitals in 1963 and they capped their numbers in 1973. At the same time, there was an expansion of community based treatment in the inpatient units attached to general hospitals and by 1999 all the large psychiatric hospitals had closed or been severely downsized.

Q. And if you were summarising - sorry, carry on.

14.52 A. No, you keep going.

Q. If you were summarising that move from institutionalisation to deinstitutionalisation , and subsequent events I've talked about inquiries and law changes, can you just expand on that?

A. Yeah. So, as the hospitals began to close in the early '90s, the money did not always follow the new services, in fact the health services took the money and a crisis led to the Mason Review in 1995-1996. And as a result of this review, and the establishment of the Mental Health

14.53 Commission, the government increased funding for community mental health services over the next decade.

And New Zealand, it is a little bit ahead of many other countries, in that about 25% of our services are community based support services and 75% of the funding goes into the traditional, you know, psychiatry hospitals.

And in anticipation, there was also a law change because in anticipation of the closure of a lot of state hospitals, New Zealand passed the current Mental Health

14.54 (Compulsory Assessment and Treatment) Act in 1992 . Now, this introduced the compulsory community treatment and I believe this has been a kind of new area for abuse but it also entitled the criteria and developed legal procedures for appeal to be released from the Act which has proven

to be equivalent.

Q. In your introduction, you mentioned that you had been part -

A. Are you there?

Q. I am. I'm having my own technology problems. In your introduction, you mentioned that you were one of the people who started the survivor movement in New Zealand. Can you talk about the survivor movement, how it came to New Zealand and what it meant?

14.55 A. Right. So, the survivor movement began with a whole lot of other liberation movements in North America and parts of Europe in the 1970s. And many people who participated in the movement had experience of psychiatric abuse - actions that had harmed their bodies, minds, spirit, self-worth and their standing in the world.

Many of these actions were done lawfully and within the boundaries of acceptable practice, so I think this is really, this is a key point. And they ranged from seclusion, forced medication, locked hospitals, physical 14.55 force, emotional neglect, degrading conditions, the pathologising of human distress, prognoses of doom and the crushing invalidation of lived experience insights. And all these forms of abuse continue today.

So, the movement didn't reach New Zealand until the mid 1980s and over a short time survivors setup local networks that provided support and advocacy, and the first national network was established in 1990. And since the mid 1980s the movement has done quite a number of things which I outlined in my statement but I just 14.56 want to highlight a couple of them today.

They put pressure on the government to establish the Confidential Forum for inpatients in psychiatric hospitals.

CHAIR: Can I intervene for a moment, Mary, to ask you

to speak a little more slowly? The evidence that you are giving is being stenotyped at very high speed but not sufficiently to cope with your speed at the moment.

A. Okay.

CHAIR: Thank you.

A. Good, I will slow down. One of the activities of the survival movement was to put pressure on the government to establish the Confidential Forum for former inpatients
14.57 of psychiatric hospitals and subsequently to make a public apology, which has not yet happened.

There was the 'End Seclusion Now' campaign in 2014 and participation in system-led projects to reduce and eliminate seclusion. We have had a reduction in seclusion but no elimination.

Research and raising awareness of the harm caused by psychotropic drugs.

And also the development of the Wellbeing Manifesto in 2018 which called for an end to health-led services.

MS JANES:

Q. Mary, you know that the Royal Commission's Terms of Reference has a definition of abuse but in your paper you've used a different definition; can you outline why that is and what your definition that you use in the paper is?

A. So, it's not really - it's just a definition. It includes all those elements but it also includes the abuse by, you know, the Royal Commission definition conceptualises abuse by the type of impact it has on the
14.58 person but it doesn't really capture the many different contexts or forms of abuse that are part of the institutional services.

And so, I sort of stretched it out a bit and talked about environmental, procedural, legislative treatment,

psychological, critical, sexual, cultural property and narrative forms of abuse.

Q. Before we turn to looking at each - carry on.

A. You carry on.

Q. Before turning to look at each of those forms of abuse, is there anything that you would like to say about the underlying dynamics of abuse?

A. Yes. So, there's a question about why has abuse in the Mental Health Services been allowed to happen so often and for so long? And why does the community accept abuse for several and not for others?

I think there's a profoundingly simple answer to this question, and that is that extreme states of mental distress have zero status as a human experience. And this taints most human responses to it.

The response might be fear, hostility, a desire to control, incomprehension, paternalism or pity. And they might be well intentions or not well intentions. But they all trace back to the ancient thing of stigma. 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 way and means of expressing stigma has varied. Over the last 200 years in the west the official expression has been four things; institutionalisation, compulsory intervention, the dominance of medicine, and for Maori the process of colonisation.

I want to go into a little bit more detail about the process of colonisation. As I said before, the Mental Health System has been part of a colonising infrastructure which has imposed additional harm on Maori. Prior to the 1960, few Maori were admitted to Mental Health Services. However, between 1959 and 1987

the number increased significantly. Throughout the 1990s and into the 2000s, Maori continued to be disproportionately represented in statistics for mental health admissions and involuntary treatment and seclusion.

Maori are 15% of the population but make up over 25% of people who use mental health services. Maori experienced increased rates of admission and involuntary treatment after the 1960s. While these increases are in
15.03 part reflected by Maori urbanisation, evidence indicates that colonisation and systemic racism were ultimately responsible.

And of course there are other groups that have been somewhat over represented or have been more prone to abuse than some others.

Women and girls, their admissions appear to have reflected prevailing norms about women's gender roles and some were sent following experience inside the social welfare system and many young women were admitted to
15.03 psychiatric hospitals with postpartum depression and often stayed for many years.

There are dynamics in play for young children who were sent to psychiatric hospitals sometimes in response to families. Men and boys who were often sent in response to anti-social behaviours. And disabled people and people with physical health conditions were subjected to forced treatment. And people with gender identity and sexual orientation that did not meet the norm, that also was led to diagnosis and forced treatment.

15.04 Q. Thank you. Moving on to the various abuse categories you outlined earlier, what do you define as environmental abuse?

A. That includes institutionalisation, locked wards, solitary confinement and separation from family and

whanau. And the Confidential Forum reported that the physical environments of psychiatric hospitals were bleak and depressing. For instance, a former staff member from Tokanui Hospital described how people were housed in large, mixed age and gender dormitories. 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.

"I worked as a Co-ordinator of Psychiatric Services and Advocacy Services in Carrington Hospital in 1988 and I observed 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 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 curtain or door lock. They faced the laundry, the property rooms and the seclusion rooms.At the end of the corridor came the dormitory".

Alasdair Russell talked to Julie Leibrich about the prison like conditions in Oakley Hospital in the early 1970s where he was a patient.

"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 tearoom door

was locked. The dayroom 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."

Q. Mary, just before we carry on, we're going to get into the area of your evidence where there are a number of quotes. Can you confirm, please, that any quotes in your evidence are either from public sources or that you have consent to use them?

15.08 A. Yes, I have got consent to use them and they are all from public sources but I sought consent from the people who are still alive but they are all published.

Q. Thank you. You then go on to talk about solitary confinement.Having gone from all of those locked rooms, there was an additional layer, can you talk a bit about that and why they were used?

A. Yes. Solitary confinement, otherwise known as seclusion, which is a term I tend not to use. It is the placing of a person in a bare room without the ability to make an

15.09 exit. It continues to be routine practice in institutional settings. And there are still seclusion rooms being built in modern acute patient units today.

Survivors at the Confidential Forum and Confidential Listening and Assistance Service talked about solitary confinement as extremely frightening and retraumatising. Threats of solitary confinement were also routinely used to instill fear and control people.

Denise Caltaux in a publication talked about her experiences of physical restraint and solitary

15.10 confinement in the early 1990s, and I quote:

"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."

I think a side room here is a solitary confinement.

"Of course we were going through the rigmarole of having to strip naked, and if you don't 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".

15.11 Egan Bidois talked recently on a podcast about the over-medication and abuses that led him to being put into solitary confinement in 1990 and I quote:

"A couple of orderlies would pick me up from my room and shuffle-drag me to the dayroom. 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're 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

15.12 cleaned off and take you to the dayroom 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."

Q. There's also the issue you talk about of separation from family and whanau?

A. Yes. According to the Confidential Forum, survivors were often forcibly parted from whanau, parents, partners or siblings. Contact with families and whanau was

15.12 infrequent.Some whanau were told by staff that it would be best to stay away. Separation from whanau left survivors more vulnerable to abuse.

Anne Helm was incarcerated in several psychiatric hospitals in the 1970s and she said:

"Remember, these were places where outsiders in the form of visitors were rarely seen."

Q. The Royal Commission heard the other day from Arthur Taylor that he had been put into a psychiatric unit without a diagnosis. In your evidence, you talk about procedural abuse, what do you mean and what examples would you like to share with the Commission?

A. I can't comment on Arthur Taylor's story but by procedural abuse, we mean processes such as admission, assessment and the administration of treatment.

Many survivors talked to the Confidential Forum and the Confidential Listening 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' judgments 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.

The Confidential Forum reported that people's experiences of trauma or adversity were usually disregarded in the assessment and treatment process. Survivors often said 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. Institutional procedures were especially harmful for Maori who have talked about having indigenous knowledge, values and experiences pathologised and medicated, resulting in a loss of Maori identity.

Q. Just to note for the Commissioners, the paper has a large number of quotes. We won't be going through each of the quotes but they are there and we would absolutely invite anyone to read those.

Mary, on that basis, can we turn to legislative abuse, please.

15.16

A. Yes. So, legislative abuse includes the use of legal coercion. I say particularly beyond the scope of the law but I believe that the law itself is abusive.

And so, 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.

15.17

Maori with lived experience, who were more likely to be sectioned than non-Maori, have also talked about the violations they experienced under the Mental Health Act. And I quote:

"I have been degraded by people in positions of authority who are funded by the tax paying 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

15.18

blatantly violated."

Q. You've also spoken about treatment abuse and you particularly talk about the effects of psychotropic drugs and also ECT, can you summarise your views on those?

A. So, in the period 1950-1999, psychotropic drugs came in in the 1950s and electroconvulsive therapy was being used before 1950. There were other treatments but these were the mainstay. Some very drastic, terrible treatments in the earlier part of the period were insulin shock therapy
15.19 and lobotomies.I will be talking a little more about ^ went into the 70s.

The use of psychotropic drugs caused a condition called tardive dyskinesia, permanent involuntary movements that included grimacing, sticking out the tongue, or smacking of the lips. And of course the hospitals prescribed Paraldehyde until the 1970s and there's a graphic description of how horrible this was for the people who were administered it in the Gallen report.

15.20 Survivors who spoke at the Confidential Forum and the Listening Assistance Service described the use of these drugs in high doses and the use of polypharmacy. They 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, many survivors as well as their family members reported that their mental health deteriorated significantly as a result of treatment.

And I want to add that the second generation
15.21 antipsychotics that have been around since 2000, also have a very poor effect on people's physical health and they are known to be life shortening.

Q. And you said you'd come back to deep sleep therapy. At paragraph 50 there's a quote that you wanted to share?

A. Yeah, so Anne Helm wrote about her experience of deep sleep therapy at Cherry Farm Hospital in the 1970s and I quote:

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

Q. And you spoke earlier about Lake Alice and Gallen J's report, what else would you say about electroconvulsive therapy?

A. So, 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 gives clear
15.23 evidence that the use of unmodified ECT went through to the 1970s at least. It also documents the use of ECT as a punishment, administered on children and young people's legs and genitals. He described these ECT practices as a regime of terror and they were reported to the United Nations Committee on the Convention Against Torture.

Q. And then at paragraph 54, there was a quote about the length of ECT treatments administered.

A. Yes. So, Egan Bidois talked about his experience of ECT and torture and I quote:

15.24 "I received", this was in 1990, "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 had 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."

Q. And another form of abuse you speak of is psychological abuse, how do you define that and what would you like to say?

A. Psychological abuse includes bullying, threats, cruelty and put-downs.

15.25 The Confidential Forum and the Listening Assistance Service reported that survivors talked about many kinds of psychological abuses by staff. This included the demeaning jokes, emotional abuse and cruelty.

Q. And then we go on to physical abuse?

A. Yeah, yeah, okay. Physical abuse includes hitting and physically forcing people.

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 the
15.25 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.

In the 1980s, I interviewed Gerald about his time in Oakley Hospital and I quote:

"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, get your pyjamas on and go to bed. I
15.26 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."

Q. From paragraph 62, you talk about sexual abuse and where that abuse came from. Can you describe further what you would want to say?

A. Yes. Sexual abuse includes non-consensual sexual contact or harassment.

These Confidential Forum and Listening Assistance Service both reported that survivors talked about sexual abuse by staff, including rape. Survivors also reported sexual physical abuse by other residents within the
15.27 context of high levels of distress, and unsafe, mixed age and mixed gender facilities.

Debbie Peterson wrote by her experiences. Are you there?

Q. Carry on. Can you hear me?

A. "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
15.28 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."

Q. You've spoken about Maori experience and you talk about cultural abuse and a Waitangi Tribunal proceeding -

CHAIR: At this point, Ms Janes, we are approaching 3.30 which might be a good time to take the afternoon adjournment. Would this be a suitable time?

MS JANES: It certainly would, Sir.

Hearing adjourned from 3.30 p.m. until 3.45 p.m.

MR MOUNT: Mr Chair, perhaps during this brief moment, I can advise those watching through you that the

witness Rosslyn Noonan who was scheduled for Monday will no longer be on Monday next week because of some logistical reasons outside everybody's control and we will have an update on Ms Noonan's evidence on Monday, I expect, if not sooner and we will let people know by means of the website.

CHAIR: Thanks very much. We will be keen to hear as soon as may be convenient.

MR MOUNT: Thank you, Mr Chair.

15.49 **MS JANES:** Just while we're recovering the witness, I want to check with the Commissioner about time constraints, it may affect what I do with the witness.

CHAIR: My colleague, Judge Shaw, I think there is an expectation that we will finish at 5.00.

MS JANES: Thank you, Sir.

Q. Welcome back, Mary, I hope you managed to have a cup of tea. We were at paragraph 66 of your evidence, talking about cultural abuse, and you were going to explain what
15.49 you meant by that and the Waitangi Tribunal proceedings?

A. Right. Cultural abuse includes colonisation, racism and denial of access to cultural world views and supports.

The WAI 2575 report on Maori health inequities states that colonisation in the form of assimilation of policies and practices and institutional racism have marginalised Maori knowledge, ways of knowing and values. Maori experiences of psychiatric abuse are compounded by the impact of colonisation and alienation from whenua, whakapapa and whanau, which are the key ingredients for
15.50 wellbeing. The Confidential Forum reported that Maori survivors experienced a violation of their cultural values, beliefs and experiences within the Mental Health System; their experiences were routinely pathologised and this caused significant harm.

Q. And it wasn't just the Maori who were impacted by this, is it?
A. No. I want to quote a young Pacifica woman who talked about racism in hospital in the 1990s and I quote:

"When I was in hospital I found all the Pakeha 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."

Q. And another aspect of abuse is property abuse and you talk about something called an interest scandal, can you outline what the abuse is and what happened with that scandal?
A. Yes. So, by property abuse, I mean withholding or stealing money or goods. So, the hospital admission process usually involved the - what paragraph? Here we go.

So, I'll just start by saying that the process involved the removal of clothing and personal property. People didn't 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 welfare benefit claimants was probably illegal.

Q. And when you talk about narrative abuse, what does that mean to you and had you had personal experience of that?
A. Yes. So, narrative abuse includes the prognosis of doom and a focus, pretty much a whole focus on people's

deficits.

Before I go on to my own experience, I want to talk about survivors and the Confidential Forum who recalled how staff often viewed them with a deficit lens and gave them a bleak narrative about their future.

And these narratives led to hopelessness and contributed to negative consequences across the spheres of survivors' lives.

My own personal experience, at the age of 21 I was
15.54 given a prognosis of doom by my psychiatrist and I quote:

"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".

And I say:

"Do I really?"

And he said:

15.55 "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 asked.

"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."

15.55 Q. I'm delighted you proved him wrong. In terms of then moving on to impact of the various abuses that you've spoken about, can you just describe those starting from paragraph 80 and the quotes that you want to share in the following paragraphs?

A. Right. So, survivors at the Confidential Forum and listening and Assistance Service reported that they continued to experience lifelong psychological stress, they recalled living with low self-esteem, frightening memory, frequent nightmares, hypervigilance, shame, grief, sadness and loss, anger and rage because of abuse within the services. Many described their overwhelming struggle to make sense of multiple abuses.

Survivors suffered losses in many areas of life. 15.56 They lost connection to whakapapa, whanau and whenua. 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.

Q. And you interviewed a number of survivors in the 1980s and reached some collusions, what were they?

A. I wrote:

"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 15.57 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 15.58 avoided if the Mental Health System and the rest of society had genuinely responded to them."

Q. And you also quote from Anne Helm about the trauma that went unattended which is a feature particularly of those with disabilities?

A. Anne wrote:

"Denial of experience also deeply buried the evidence 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."

15.59 Q. And can you briefly summarise the impact of abuse on poor life and health outcomes?

A. Yes. So, many survivors talked about 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. Many relied on Income Support or ACC and had to deal with the Work and Income or ACC staff whose processes often mirrored the abuse in

16.00 Mental Health System - of being monitored, misjudged and incorrectly written about after sharing intimate details of their lives. And that was to the Confidential Forum.

Q. We've spoken about broken whanau community connections and the impact on Maori but is there anything further that you would like to say about those before we move on to another topic?

A. Yes. The stigma of being admitted to a psychiatric hospital, coupled with routine medical advice at the time often meant long-term separation from families and

16.01 whanau. Most whanau visited infrequently or stayed away. For some survivors, disconnection from families and whanau resulted in a lifelong sense of abandonment and feeling of not belonging. Sometimes ashamed families and whanau 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. And this was again through the Confidential Forum.

Q. And you've got a quote at paragraph 92 where Kaimahi Maori told the addiction Inquiry something that may resonate with many. Can you share that with the Commission, please?

16.02 A. Yes. This was from - so, this Kaimahi Maori said:

"Whanau are fearful of our ministries, fearful of mental health, fearful of Oranga Tamariki taking our children. Fearful of Police who take away their Dads. Whanau are on the back foot before anything that happened, just because they are Maori."

And I have another quote here from the whanau of a person with lived experience who talked about the corrosive impact of colonisation and alien systems on Maori:

16.03 "These alien systems denied (and still do) the harm that had been wrought in the collective body, mind and heart of Maoridom, while at the same time demonising Maori people and culture for the outcome of these harms. Alongside widespread economic, physical and spiritual deprivations from the erasure of conditions necessary for life, and also our spiritual and wellbeing institutions and practitioners, systemic denigration of Maori began to carve into my grandfather and grandmother's hearts and minds, the notion of their superiority and fated

16.04 impairment. They began to despise themselves in all things Maori as they internalised and acted out colonial induced systemic self-hate. The echoes of this hate infestation continue to resound throughout our personal and collective hearts and minds."

Q. Mary, we then turn to Mental Health Services after 1999 and you've quoted from the Mental Health and Addiction Inquiry. What would you like to say about what could or should happen into the future?

A. So, there have been some good developments in Mental Health Services since 1999, particularly the growing of community support services but we still have a system where clinical approach is dominant. There is still continuing institutionalisation and we have rising rates of compulsory treatment.

16.05

I want to focus a bit on compulsory treatment. Many submitters to the Government Inquiry into mental health and addiction spoke of their experience of compulsory detention often for long periods of time, being forcibly treated and being denied the right of self-determination and participation without treatment.

They also described the trauma associated with compulsion, the adverse impact of forced medication and the harm caused by solitary confinement.

16.06

And I quote from the Inquiry report:

"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".

Q. To try and shine some light into the doom, have there been any changes that have any impact to stop abuse since 1999?

16.06

A. There have been changes and there have been some developments but I think they really have yet to reach fruition, and that's both at the international and national level. You know, 20 years on, abuse in Mental

Health Services continues, despite the closure of the long stay institutions, rhetoric about recovery and the development of human rights protection.

Q. And there have been the United Nations Convention on the Rights of Persons With Disabilities and the rights of Indigenous Peoples; is there anything you'd like to say about those developments?

A. Yes. The UN Convention on the Rights of Persons with Disabilities states that persons with disabilities, and
16.07 that includes 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.

16.08 Member states, including New Zealand, appear to be in denial about the full implications of the Convention, and they respond to the Convention by seeking reformed legislation, rather than repeal.

Q. And do we know, one of the recommendations from the Mental Health Addiction Inquiry was replace and repeal the Mental Health (Compulsory Assessment and Treatment) Act, do you have any sense about whether that will resolve the concerns that you've expressed in your evidence completely?

16.09 A. So, I don't have a lot of confidence that replacing the Act, as is the plan, is going to resolve the issues in a thorough way and there is good evidence and anecdotal evidence from Victoria and Australia, that changing the Act does not make any difference to what actually

happens. And that's because the people who administer the Act, they may be chastised for not using it enough, they're never chastised for using it too much.

Q. In terms of the rights of Indigenous Peoples, how would you characterise the involvement of the Treaty of Waitangi in Mental Health Service design and delivery?

A. Well, the UN Declaration on the Rights of Indigenous Peoples specifically recognises the rights to enforcement of Treaty and that includes the Treaty of Waitangi. I'm
16.10 going to be talking a bit more later on about the implications of this for Maori service development going forward.

Q. And very briefly, there have been inquiries and compensations and apologies. So, from paragraph 106 you talk about the Lake Alice settlement and the Crown Health Financing Agency. Can you just summarise your thoughts on those points?

A. Yes. So, the Confidential Forum for former in-patients of psychiatric hospitals was established in 2004 but its
16.11 Terms of Reference was kept narrow, I believe 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 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
16.12 apology for compensation for survivors and this is something that is very keenly felt by some survivors. And I want to acknowledge Anne Helm who was on the Panel of the Confidential Forum, who is herself a survivor, and the valiant effort she took after the forum reported to

organise an apology but to no avail.

So, we really believe that the Royal Commission is our next opportunity for this to happen.

The Residual Health Management Unit, which was later named the Crown Health Financing Agency was formed in 93 to manage the residual public health system assets and liabilities that could not be transferred to the new Crown Health Enterprises. Among them were claims associated with historical abuse and neglect in
16.13 psychiatric hospitals. By 2011 the Crown health funding agency 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.

Q. Turning then to complaints and resolution mechanisms. You've talked about three mechanisms but can I just point
16.14 you to paragraph 110 where you talk about people under the Mental Health Act and the Review Tribunal. You had specific thoughts about that?

A. People subject to the Mental Health Act can since 1992 seek review through the Family Court or the Mental Health Review Tribunal. There is strong evidence that these processes put in place to protect human rights and prevent Mental Health System abuse do not work well. For instance, in 2017, the mental health Review Tribunal heard 62 applications for release from the Act. Of those
16.15 applications, only six people were released.

Q. And in terms of the programme to achieve zero seclusion by 2020, what are your thoughts on that, and in particular in relation to Maori and the use of seclusion and restraint?

A. There have been some successes but the mental Health Commissioner has recently highlighted a high rate of seclusion for Maori and noted that although the overall seclusion rate has decreased 30% since 2007, the seclusion rate for Maori has only decreased by 9%. In 2016, 102 young people aged 19 or less were secluded. There remained wide variation in the use of seclusion and restraint across District Health Boards. Seclusion rooms continue to be built in new mental health facilities in 2019.

16.16

Q. Mary, under the Terms of Reference, the Royal Commission has a forward looking mandate and you've spoken about the e Kore Ano campaign that led to the Royal Commission. I would like to invite you to read from paragraph 115 because you have set out what your thoughts are about areas the Royal Commission could think of so it doesn't happen again.

A. Yes. 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 diagnosed with "mental illness" and psychiatry is replaced at the hub of the system by communities who control the narrative and resources, including Maori, Pasifika and people with lived experience of distress. At the same time, we need to continue to work to reduce stigma and discrimination in the wider community.

16.17

I'm now going to talk about redress and rehabilitation. 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 acknowledgment and the settlement process

16.18

with affected individuals has not been completed.

And these statements were echoed by Judge Henwood in her report of the Confidential Listening and Assistance Service.

The Royal Commission provides an opportunity to establish a more deliberate and comprehensive redress and rehabilitation process. And I think the survivor perception of the process so far, is that it has been piecemeal and half hearted, and I think the Royal
16.19 Commission needs to show that this country has a commitment to redress and rehabilitation. And of course, survivors need to lead decision-making about this process.

I want to talk a little bit about a good process and for this I thank Dr Heather Barnett. 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.

16.19 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 straightforward and prompt.

I now want to go on to the issue of apology. Survivors of psychiatric abuse have called for two public apologies. One from the State and one from the Royal
16.20 Australian and New Zealand College of Psychiatrists. Survivors need a "complete apology", as Marist elucidated. This includes an acknowledgment 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.

We haven't achieved this in New Zealand and felt in the paper quoted in her statement, felt that the government apology on the Lake Alice abuse did not reach the threshold in Marist's definition.

16.21 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 whanau.

Survivors have called for a belated public acknowledgment of the report of the Confidential Forum published in 2007. They are seeking acknowledgment of the report that started the Royal Commission of Inquiry's

16.22 report and identification of how the voices of people who participated in a Confidential Forum have been included in the Royal Commission's processes and recommends. They also want the report to be more widely disseminated throughout New Zealand.

I want to talk about monetary redress. Monetary redress needs to involve consideration of five key factors. Is it in the survivors' interests? Are realistic costs given by the State? Is the process transparent?Does it include ongoing support for

16.23 survivors?And is justice being served to survivors?

If you haven't already, I would ask you to read Winter 2018 cited in this report. Winter compares the processes for people who are State wards in New Zealand and Ireland. New Zealand does not come out very well in

that comparison. He said the costs awarded by the State were very low in New Zealand compared to Ireland, probably about, I think about 1/5th. And I think also there may be consistency between the Lake Alice pay out and pay outs that have been subsequently given for instance through the Crown Health Funding Authority and I think probably needs further examination. Has there been consistency to date? But certainly to ensure that we have a realistic and generous pay out and not a little
16.24 wellness payment.

Winter said that transparency of process is very low in New Zealand. And he was saying that the process was widely advertised in Ireland but in New Zealand very few people know about the process that's going on in health, the monetary redress in health, social development and education. And they don't advertise them because they feel flooded but that does not justify not letting people know that these processes are available.

Q. Mary, I just want to, I am conscious of the time. We are
16.25 at 4.30 and we need to finish by 5.00 and there will be some other questions for you.

Could I ask you to quickly summarise funding for healing and your thoughts on the clean slate policy and other remedies. Thank you.

A. Yeah. Funding for healing need to be part of a broader package, should be available for as long as the individual needs it and the nature of the approach needs to be broadly defined. This may include access to Kaupapa Maori, re connection to whanau, hapu and iwi,
16.26 alcohol and drug counselling, sexual abuse counselling, peer support services and so on.

And I would also like to talk about the clean slate policy that survivors have spoken about 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.

And there are some examples of clean slate systems around the world.

There are some other remedies which I think are interesting because they are a bit more lateral than the
16.27 traditional remedies. I have cited some examples in my paper. A national memorial to publically acknowledge people who were abused in State care.

A national approach to remembering the people who died in psychiatric hospitals and were buried in unmarked graves.

Compulsory education about state abuse as part of the national school curriculum at primary and secondary levels.

Guaranteed access to university or tertiary
16.27 education, placement in a programme of choice, and payment of fees, costs and living expenses for this purpose.

Free access to survivors to numeracy and literacy education.

Free access for survivors to primary health services. And these are all excellent examples that occur somewhere in the world.

To conclude, the road to the Royal Commission is lined all the way back to the 1840s with the casualties
16.28 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 overview opportunity for New Zealand to draw a line in the sand and to say e kore ano - never again.

Q. Thank you, Mary. I just have a few supplementary questions that hopefully we can quickly go through.

Just returning to the Mental Health and Addiction Inquiry, do you have any views about whether more work is
16.29 required to mental health systems for Maori and to incorporate Kaupapa Maori alternatives to psychiatry?

A. Look, Maori expressed disappointment in the Inquiry. And one of the issues was the lack of recommendations specific to Maori, including the lack of a recommendation for the establishment of a Maori health authority. The report referred this on to the Health and Disability review and I don't see hopeful signs that the Health and Disability review will result in a Maori health authority. After 170 years of systems failing Maori,
16.30 they are calling for control over planning, funding and delivery of their own services and support. And I support this and I do hope that the Health and Disability review supports this as well.

Q. And turning to another topic. Your evidence didn't give a ringing endorsement of Mental Health Services, particularly Psychiatric Services. What alternatives would you see to that clinical model in terms of psychiatric models, drug treatment, compulsory orders and the like?

16.31 A. People with lived experience outline an alternative in the wellbeing that exists for Aotearoa New Zealand which was a major submission to the Mental Health and Addiction Inquiry. With your permission, I could append that to my evidence statement.

The Wellbeing Manifesto calls for an end to a health-led system and talks about the need to move from big psychiatry to big community. And it describes what big psychiatry and big community are.

In big psychiatry, we have deficits based, we have a view about mental disorder, which is deficits based. In big community, we talk about the stress that we can recover from.

In big psychiatry, entry to the system is done by
16.32 health. But in big communities, we need multiple entry.

Most of the dollars, as I said before, in big psychiatry still go into what I call pills and pillow services. And we need far more resources to go into the broad menu of services and supports for people.

You find in big psychiatry that most of the people who are paid to be there, are medical and allied professionals. In big community, we are proposing we have an equal mix of peer, cultural and professional workers.

16.32 Big psychiatry has a legacy of abuse and neglect. And big community has a commitment to human rights partnership.

There is a dynamic in big psychiatry arrange risk management. They are very focused on managing immediate risk. But in big community, the focus is on access, seeing people's strengths and actually being accountable for long-term life outcomes.

Big psychiatry is a major tool of the Mental Health Act with hospitals, big tools for people who are
16.33 struggling, crisis and big psychiatry, compassion, insensitive support and a community based crisis benefit.

And, as I said, big psychiatry is an agent of colonisation that promotes one world view. Big community needs to include multiple world views.

Q. Thank you, and with the permission of the Commissioners, we will actually enter that too and it will be Exhibit 10.

Report produced as Exhibit 10

CHAIR: Thank you.

MS JANES:

Q. Slightly different topic, you talked about Lake Alice and Porirua and experimental and punitive treatments. Were they more widespread than those two organisations or
16.34 institutions at the time, and what about now?

A. Look, I think the type of abuse that I described are less widespread today because, simply because there are less people in long stay institutions. But let's be clear, it still happens. And abuse doesn't just happen in the name of experimental or punitive treatment. It can be a part of industry and, as I said, put someone on a community treatment order, on drugs that can shorten their life, to me is an abuse. And this happens thousands of times every year in New Zealand.

16.35 Q. From your perspective, what are the general attitudes that allow or sustain abuse to continue? And particular with reference to the concepts of mentalism and ableism and discrimination of disabilities?

A. As I said earlier in my statement, stigma prejudice and discrimination allow a sustained ableism and mentalism and that's why programs such as like minds like minds programme that hold the mana and human rights of people with mental distress are so important and need continued and generous resources.

16.36 Q. And you set out a fairly comprehensive recommendation of what you thought would be helpful in the way forward. But if you were saying to the Royal Commission that at the end of this process, from your perspective are we looking at a tweak or a fundamental transformation?

A. I think a tweak will lead to the same disaster. We need a fundamental transformation. And I gave you a hint of what that might look like in my answer to question three and in the Wellbeing Manifesto.

The first thing, in order to achieve the fundamental transformation, our laws need to comply with the United Nations Convention on the Rights of Persons With Disabilities which can only mean the end of the Mental Health Act and a move to supportive decision-making. There is no other interpretation from 95% of the commentary that is coming out of the United Nations.

The other thing is, we keep building more hospital beds. Every time I hear an announcement of a new ward or a facility, I want to weep because despite people's best efforts, these wards are on the whole unsafe, unhealing and a coercive environment. We need to drastically down size hospital beds and create home life and humane crisis services in the community.

As I said, psychiatry is the dominant, singer dominant force, and it needs to move from the hub of our system and become one of the spokes. We need people with lived experience in multiple sectors of the hub, developing policy, jointly funding and delivering a broad range of services and support.

I'm not anti-psychiatry. I'm anti-dominant psychiatry.

Finally, we need to wholeheartedly, and I mean wholeheartedly, address the impacts of colonisation by giving back control to Maori, fund and provide services and supports to Maori.

And in order to lay the ground for these changes, we have to fully reckon, acknowledge the harm done, provide redress and rehabilitation, in a very comprehensive planned and whole hearted way.

Q. Thank you, I have no further questions but stay on the line and I'll check with the Commissioners do before we disband.

CHAIR: Thank you. I'll first of all ask counsel if any have a wish to address cross-examination to Mary O'Hagan? There's none.

Can I then ask my colleagues if there are any questions and shall I start with Mr Gibson?

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MARY O'HAGAN

QUESTIONED BY COMMISSIONERS

COMMISSIONER GIBSON: All my questions have been answered, thank you.

CHAIR: Thank you.

COMMISSIONER ALOFIVAE: Nothing further from me, thank you.

16.39

CHAIR: Judge Shaw?

COMMISSIONER SHAW: Mary, thank you very much for your evidence. I just have a short question on your paragraph 108 of your brief of evidence, in which you refer to the fact that the CHFA developed a settlement strategy because it had received 336 psychiatric patient claims. Are you with me there?

A. Yes, I am.

COMMISSIONER SHAW: Thank you. I have two questions about that.

16.40

Do you have any idea what the period over which those claims were received was?

A. I don't. I think they went back, you mean the period of the abuse or the period the claims were made?

COMMISSIONER SHAW: The period the claims were made.

A. I don't know but I am sure that information could be sought from Graeme Bell who is the former CEO of CHFA or someone who is currently working in this area, in health.

COMMISSIONER SHAW: I have a motive for asking the question. I just wonder whether you think that the number of 336 claims is a true reflection of the numbers of people in psychiatric care who suffered abuse and neglect?

16.41

A. No, I think it's a drastic - I think it's a very small

number. And, as I said, you know, I remember finding out about this and I was active in the movement and I didn't even know this process existed until someone pointed it out to me. So, they're very much under the radar and I don't think that is a good way of running such a process.

COMMISSIONER SHAW: Thank you, Mary. No other questions.

COMMISSIONER ERUETI: Dr O'Hagan, I just want to thank you for your thoughtful and comprehensive brief of
16.42 evidence. I really enjoyed reading that and hearing from you.

I want to thank you in particular for the emphasis and the attention that you have directed towards Kaupapa Maori subjects. Of course, it will be critical for this Royal Commission to hear directly from Maori themselves and Maori pukenga on this kaupapa, both mental health and learning disabilities but I want to acknowledge the mahi that you have done and I found it have valuable, kia ora.

CHAIR: Mary, I have the final word which is to thank
16.43 you sincerely on behalf of the Royal Commission for your evidence and the way in which you've been able to give it, notwithstanding the technological difficulties that we have encountered this afternoon. Thank you very much.

A. Thank you.

MS JANES: Thank you, Mary, and I really appreciate your forbearance and patience and everyone else's in the room as we've gone through this afternoon, thank you.

16.43 **CHAIR:** Thank you. Madam Registrar, can you invite Ngati Whatua to come forward and to conclude our proceeding for today.

(Closing waiata and karakia)

Hearing adjourned at 4.45 p.m.