New Zealand's Mental Health District Inspector in historical context: "The impartial scrutiny of a citizen of standing"

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The Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ) legislates for District Inspectors who ensure that mental health consumers held under the Act are aware of their legal rights. The New Zealand District Inspector role first appeared in 19th century legislation. Its historical longevity does not, however, denote that this role has been consistent since its inception. This article looks at the historical development of the District Inspector and its companion role, the Official Visitor, focusing in particular on the period 1969-1992, when the purpose and scope of the roles was part of a Mental Health Act 1969 review. This was a time of fundamental social and professional change, shifting ideas of psychiatric practice, new locations of treatment, and growing emphasis on patient/consumer rights. The sometimes heated debates surrounding the roles reflect these changing ideas. An historical analysis of the District Inspector and Official Visitor roles aids understanding of how the social and political contexts affect mental health issues; this has relevance for current mental health law.

INTRODUCTION

District Inspectors (DIs) are legal watchdogs for New Zealand mental health patients.[1] The role of DI, alongside that of the Official Visitor (OV) is designated in the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) (*Mental Health (CAT) Act 1992*) to protect patients' rights.[2] They have three core functions: to monitor the rights of individuals detained under the Act; to inspect services; and to investigate complaints.[3] These functions are by no means tokenistic. Guidelines for the DI role detail rigorous requirements for monitoring, including an obligation to visit every person brought under the Act in order to provide information and check that documentation complies with procedural steps outlined in the legislation.[4] The DI and OV roles differ in two respects: the DI position must be held by a barrister or solicitor and only a DI can conduct formal inquiries. Although the Act allows for both the DI and OV roles, no OVs have been appointed since the Act was passed. This absence is notable given that DIs and OVs previously functioned in tandem under New Zealand mental health legislation for more than 100 years. Questions therefore arise about how the roles came to be constructed in their current form and why the DI survived implementation of the Act while the OV did not.

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[1] The word "patient" is the term used in the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ). The authors acknowledge that terms such as "service user" and "consumer" are more commonly used today and denote greater respect for the autonomy of individuals who use mental health services.

[2] For a concise overview of changes introduced under the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), see Dawson J and Gledhill K (eds), *Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) pp 17-25.

[3] *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ), ss 75, 96, 95.

[4] New Zealand, Ministry of Health, *Guidelines for the Role and Function of District Inspectors: Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health, Wellington, 2012).

Legislative changes can be best understood within their contemporary and historic contexts. The current statutory roles of DI and OV were formulated during the lengthy review of the *Mental Health Act 1969* (NZ). One contemporary commentator, John Dawson, argued that the new *Mental Health (CAT) Act 1992* "should be understood within a wider legislative context, against a backdrop of hospital closures and changing practice in psychiatry".[5] This is an important element of this article – to place the *Mental Health (CAT) Act 1992*, and the roles of DI and OV specifically, in its broader context. That context includes the issues Dawson mentioned – shifting ideas of psychiatric practice and the changing physical environment of mental health care – as well as the context of a new emphasis on civil rights that influenced many spheres of public life. This article explores the, at times, heated negotiations during the lengthy period of legislative review and posits some explanations about the contested positions based on the contemporary historical context.

To understand the debates of the 1970s and 1980s, and in particular, the ambivalence concerning the OV role, it is necessary to appreciate the changing place these statutory watchdog roles had occupied in New Zealand mental hospital services. As reviewers of the *Mental Health Act 1969* sought to address patient rights better, they questioned whether the existing DI and OV roles would suffice for the purpose. Arguments largely focused on advocacy and professionalisation. This article explores the origins of the DI and OV roles and traces their development since the 19th century. In doing so, this article asks whether the notions of rights, advocacy and professionalisation associated with the late 20th century were new concepts or were they in some ways, continuous with the past?

HISTORICAL ORIGINS OF DI AND OV ROLES

New Zealand's mental health laws regulating the detention of "mentally disturbed" individuals and the administration of psychiatric institutions have been in place in one form or other since 1846. The *Lunatics Ordinance 1846* (NZ) provided for the detention of a person considered to be "dangerously insane" or "of unsound mind" in a gaol, hospital or asylum. Although, at the time, there were no asylums, the legislation anticipated their future existence and the need for external review. It allowed the Governor of the Colony to "nominate and appoint some fit person or persons to be visitor or visitors of such lunatic asylum".[6] Requirements of the role, however, were left to the discretion of the Governor.

It was not until 1868, under the much more comprehensive *Lunatics Act 1868* (NZ), that the role of Inspector and OV were clearly defined. Although a precursor to the DI role, the term "Inspector" was used in this Act. By this time, a network of provincial asylums had been established throughout New Zealand, numbers of patients were steadily growing and concerns were periodically raised about conditions.[7] Under the *Lunatics Act 1868*, an Inspector was to be allocated to each district and one or two OVs to each mental hospital or asylum. Extensive instructions were given for inspection of "every asylum and hospital and every licensed house for the reception of lunatics". Instructions included who should undertake them, how often, what they need to look for, and the necessity for recording observations in a visitation book and patients' books. The Act made provision for payment of Inspectors provided that during their term of office, neither they nor their immediate family members or (business) partners worked as a "physician, surgeon or apothecary". Presumably, this stricture was designed to prevent Inspectors taking advantage of vulnerable patients for their own financial ends. The efficacy of payment for Inspectors and OVs was debated from time to time over the next century.

The *Lunatics Act 1868* (NZ) was modelled on contemporary English legislation, and reflected that country's growing commitment to lunacy reform. Since the *Madhouses Act 1774* (UK), there had been provision in England for inspectors of madhouses, though initially these were medical men with limited access to, or authority over, the mainly private institutions they were charged with visiting.

[5] Dawson J, "The Mental Health (Compulsory Assessment and Treatment) Act 1992: Significant Advance on Previous Law" (1992) 378 *Law Talk* 3.

[6] *Lunatics Ordinance 1846* (NZ).

[7] Brunton W, "A Choice of Difficulties: National Mental Health Policy in New Zealand, 1840-1947" (Thesis, Doctor of Philosophy, University of Otago, 2001).

Through a series of legislative changes culminating in the *Lunacy Act 1845* (UK) and *County Asylums Act 1845* (UK), a Lunacy Commission was established to oversee the building of county asylums and to regulate and monitor care of "lunatics" in any setting. Many of the instructions for visitation and inspection under these Acts were directly represented in the *Lunacy Act 1868* (NZ). Details such as frequency of visits (every three months), 24-hour access to asylums without announcement, and rights to inspect any part of the buildings or grounds, examine records and inquire about restraint were almost identical.

What was different between the two countries was the regulation concerning qualifications of inspectors. In England, one third of the Commissioners had to be lawyers, one third medical men and one third laymen. In New Zealand, the only requirement for inspectors was that they could not be a medical person. An OV, on the other hand, had to be a justice of the peace. This loosely paralleled the situation in England where inspections outside the metropolitan areas were conducted by county visitors who were justices of the peace.

By the early 20th century, the mental health landscape in New Zealand had changed. From 1876, with the abolition of the Provinces, all public asylums had been brought under the umbrella of central government within a new Department of Lunacy, later renamed the Department of Mental Hospitals, headed by the Inspector-General of Mental Hospitals.[8] Departmental policy dictated a shift towards a more medical approach with medical superintendents replacing lay head-keepers and training established for mental attendants and nurses. This change in focus was formalised in the *Mental Defectives Act 1911* (NZ). Under the Act, voluntary admissions to mental institutions were allowed, terms such as "asylum" were replaced by "hospital" and the law was extended to include mental deficiency and epilepsy. Central government administration of mental hospitals continued for almost a century.

Inspectors, now termed DIs, and OVs were now appointed to specific districts. Visitation remained the core function of their roles. The central purpose of the visits was to inspect every institution in which a person was detained to ensure that the conditions were appropriate and the person treated humanely. From about this point, however, the two roles became more distinct: while OVs no longer needed to be a justice of the peace (dispensed with in 1894), the Act dictated that at least one DI in each district must be a barrister or solicitor.[9] This stipulation for legal qualification remained until the *Mental Health Act 1969*, the next major revision of the legislation, when it became compulsory for all DIs to be a barrister or solicitor.

DI AND OV ROLES: APPOINTMENT, PAYMENT AND IMPLEMENTATION

Official Visitors and DIs were appointed by the Minister of Health. Recommendations usually came from medical superintendents, though in later years, local law societies played a central part in nominating lawyers for the position of DI. Appointments were for a period of five years. For the role of DI, Ministers sought lawyers "of some seniority and standing": a lawyer needed to be experienced, level-headed and unbiased. These attributes were particularly important in the event that the DI had to undertake an inquiry and call witnesses. As one Minister of Health explained, "[t]he District Inspector is not generally an onerous appointment, but it is nevertheless a responsible and important post … a means of reassurance to the public that our psychiatric hospitals are open to the impartial scrutiny of a citizen of standing".[10]

Impartiality, respectability, and social concern were deemed essential attributes for an OV. They did not need to be highly qualified but they must be "people of common sense and humane feeling".[11] Lists of OVs included people with social justice links such as Reverend Jasper Calder who established

[8] There was only one private asylum, Ashburn Hall, established in Dunedin in 1882.

[9] *Mental Defectives Act 1911* (NZ), s 41(1)(c).

[10] Speech by the Minister of Health to the Manawatu District Law Society, 2 October 1976, ABQU 632 W4452 Box 140/30/39 (52663), Archives New Zealand, Wellington.

[11] Extracts of Recent Criticisms, Official Visitors-Both Sexes-To Mental Hospitals, April/May 1938, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

the Auckland City Mission in 1920 and Mrs Armitage who was involved with the Methodist Orphanage in Mt Albert, Auckland.[12] Respectability and being known by "the right people" was an asset. When Malcolm Brown, Medical Superintendent of Seacliff Hospital recommended Mrs Reeves as OV, he described her as "a keen social worker … [who] is known to the Honourable Minister of Health".[13] Conversely, a Minister of Health was not likely to appoint someone with questionable morals or business practices. In 1930, Theodore Gray, the Director-General of Mental Hospitals strongly opposed the appointment of Mr Prosser of Porirua because of his business links with horse racing and liquor, although he had the advantages of being a "Maori linguist". Gray argued that the appointment, would "deprecate the standing of our official visitors in the eyes of the public".[14]

Being independent was deemed essential for both DIs and OVs. Members of the public service were not accepted, nor anyone with business connections with the hospital. A baker, Henry James Harris, for example, was turned down for appointment as OV at Nelson Mental Hospital in 1919, because he held the hospital's bread contract.[15] Medical superintendents were also reluctant to give free access to their institutions to people who were considered "busybodies" or had an axe to grind.[16] In 1944, a member of the Mental Hospital Reform Association was rejected on the grounds that appointments such as his could result in "unnecessary and useless friction between the association they represent and the Mental Hospitals Dept".[17] Although social standing was considered important, political or group affiliation was not. In 1937, when the Otago Branch of the New Zealand Labour Party tried to nominate people "from the ranks of the workers", the Minister of Health explained that "it is no importance whether visitors belong to any particular class or section of the community. All I am concerned about is that they are sensible and kindly people".[18]

Questions of remuneration were intertwined with issues of independence and social class. Through most of the 20th century, the Department of Mental Hospitals (later, a division of the Department of Health) held the view that the DI role should be voluntary and part-time. This was considered essential for maintaining the DI's independence from mental health services. As Stanley Mirams, the Director of the Division of Mental Health explained, "the appointment is an honorary one and it is expected that it will be undertaken by someone with a sense of public duty and an interest in the particular problems of mental health legislation".[19] It was, however, established practice to reimburse a DI's expenses when conducting investigations.

The Department's views on remuneration for OVs were not as stable. In the early 20th century, the Department favoured the appointment of the "independent respected man"; the implication being that the OV would work in a voluntary capacity. There were, however, instances when "a working man" was appointed to the role and paid for his trouble.[20] By the 1920s, OVs were paid one guinea per visit for up to 12 visits per annum but this was discontinued during the economic depression of the

[12] List of District Inspectors and Official Visitors, 17 August 1939, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[13] Letter from M Brown to T Gray (Director-General, Mental Hospitals Department) 22 April 1938, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[14] Letter from T Gray to the Hon AJ Stallworthy, 22 September 1930, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[15] Memo from F Hay (Inspector-General, Mental Hospitals Department) to the Hon GW Russell (Minister of Health), 25 March 1919, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[16] Memo from F Hay to the Hon GW Russell, 29 March 1919, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[17] Letter from HM Buchanan (Medical Superintendent, Auckland Mental Hospital) to F Hay, 11 July 1944, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[18] Letter from P Fraser (Minister of Health) to the Secretary, Otago LRC, 8 September 1937, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[19] Letter from SWP Mirams (Director, Division of Mental Health) to Mr and Mrs G Rottcher, 10 October 1977, ABQU 632 W4452 Box 140/30/39 (52663), Archives New Zealand, Wellington.

[20] Memo from F Hay, n 16.

1930s.[21] By the 1950s, the Division of Mental Hygiene instigated reimbursement for OVs for actual and reasonable travel costs but Ronald Lewis, the Director, considered that fee for service was unacceptable, "the very nature of this position is one which should be divorced entirely from monetary reward".[22] It seems that honorary status was deemed necessary to ensure independence.

How the roles were implemented

Although the legal requirements of the DI and OV roles changed very little between 1911 and 1992, in practice, the DI and OV roles diverged somewhat from each other, and were carried out with varying degrees of diligence. The OV came to be seen more as a "patient's friend".[23] Many OVs visited their allocated hospital more frequently than required and spent time talking with patients, assisting with simple tasks and listening to their concerns. In 1919 at Seaview Hospital, for example, Mr Vail, visited daily and two female OVs showed a "great interest on female side" helping with activities such as Sunday reading and singing.[24] Not all OVs were as attentive: some rarely visited their institution.[25] Conscientious OVs checked that patients were provided with basic necessities such as food, heat and clothing, some going as far as tasting the food to check its quality.[26] They were also often the first to hear patient complaints. As one medical superintendent explained in 1940, they were "a regular channel through which they (patients) can air freely their grievances".[27] Forty-five years later, another hospital explained that the OV's duty was to look after the interests of patients, intervene when problems occur between staff and patients, and make themselves available to relatives, friends and members of the public: "They are good listeners, are easily approachable and have a wide understanding of humanity."[28] Official Visitors usually raised issues of concern with the charge nurse or medical superintendent in the first instance.

The DI role was more formal. A 1983 report noted, "the legal qualifications and special powers of a District Inspector would lead him to conduct his responsibilities rather more formally than would an Official Visitor".[29] District Inspectors, like the OVs, made recommendations in relation to physical conditions and treatment. In the early decades of the 20th century, these often focused on issues such as overcrowding, ventilation, shortages of staff, and the need for better "classification" of patients.[30] In later years, DIs responded more to specific requests by patients and inquiries into breaches of rights or legal irregularities.[31] They also inquired into complaints, some directly raised by patients or family,

[21] Duties of an Official Visitor, circa 1920s, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington; Memo from HM Buchanan, 1 April 1931, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[22] Circular letter from RGT Lewis (Director, Division of Mental Hygiene) to Medical Superintendents, 19 May 1950, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[23] Letter from LW Gribben (Medical Superintendent, Sunnyside Hospital) to F Hay, 11 April 1919, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington; Memo from B James (Director of Mental Health), 19 October 1988, ABQU 632 W4452 Box 1738 355-2-9 (64468), Archives New Zealand, Wellington.

[24] Memo from F Hay, n 15.

[25] Letter from the Medical Superintendent, Waikeria Reformatory to F Hay, 14 September 1920, H1 Box 124 30/39 (30288), 1919-1965, Archives New Zealand, Wellington.

[26] Official Visitor's Report, Auckland Mental Hospital, 28 June 1920, YCAA 1049 Box 1 Female Visitors' Book 1897-1920, Archives New Zealand, Auckland.

[27] Letter from HM Buchanan to T Gray, 14 October 1940, H1 Box 124 30/39 (30288), Archives New Zealand, Wellington.

[28] Tokanui Hospital Information Sheet for Relatives, May 1985, ABQU 632 W4452 Box 140 30/39 (59408), Archives New Zealand, Wellington.

[29] Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (The Committee, Wellington, 1983) p 135.

[30] Report on Auckland Mental Hospital by H McLean, Assistant Inspector, 13 February 1919, YCAA 1049 Box 1 Female Visitors' Book 1897-1920, Archives New Zealand, Auckland; Untitled article, *Evening Post* (19 September 1935) p 18.

[31] Letter from M Loughnan to the Chairman, North Canterbury Hospital Board, 24 October 1978, ABQU 632 W4452 Box 140/30/39 (52663), Archives New Zealand, Wellington; District Inspector/Official Visitor Information, circa 1981, ABQU 632 W4415 Box 64 30/39 (55191), Archives New Zealand, Wellington.

others indirectly via OVs, judges, the Department of Mental Health or the Minister of Health.[32] DIs tended to visit the hospitals less frequently than did the OVs. Most were diligent in their duties, but some showed little interest in visiting; after only two visits to the mental hospital, one Christchurch DI was heard to say, "I don't see any use in coming here".[33] His lack of interest was considered indicative of the problems the Department was experiencing in trying to recruit DIs in the region.

Context of change, 1970s and 1980s

Despite the historical longevity and relative stability of the DI and OV roles, the context in which they worked had changed substantially by the 1970s and 1980s. By this time, deinstitutionalisation was underway in New Zealand, mental hospital populations were shrinking, and psychiatric services were increasingly being offered at general hospitals or in the community.[34] Following the transfer of psychiatric hospitals from the Department of Health to local hospital boards in 1972, the role of OV was considered no longer necessary. It was assumed that the functions would be taken over by members of the local hospital boards. Only two hospitals, Sunnyside in Christchurch and Lake Alice in Marton, continued to appoint OVs.[35] In the case of Lake Alice, OVs were considered important because the hospital with its National Secure Unit was still under the control of the Department of Health.

International awareness of human rights drove reform of mental health legislation in many developed countries at this time. Influencing this were social movements calling for civil rights of people previously socially or politically disenfranchised; this included the black rights movement, women's liberation, gay liberation, and the disability rights movement. The anti-psychiatry movement that challenged the very foundations of medical psychiatry intersected with the rights movements and provided a theoretical platform for patient resistance and self-advocacy. During the 1970s, psychiatric patients, redefining themselves as consumers or survivors of mental health services, forged self-help and political action groups that became known as the consumer or service-user movement, or in the United Kingdom, the user movement.[36]

New Zealand was part of these human rights developments. During the 1960s and 1970s, Maori called for greater political recognition as the indigenous people of Aotearoa/New Zealand and demanded the return of tribal land. Notable events during these decades included the formation of Nga Tamatoa (the Young Warriors) in the 1960s, the Maori Land March in 1975 and the occupations of Raglan Golf Course in 1977 and Bastion Point in 1978.[37] The women's movement, demanding among other things liberalisation of abortion laws, gained momentum during the 1970s, as did the call for gay rights. Anti-racist sentiment drew people from all sectors of society to protest against the Springbok Rugby Tour in 1981. At a government level, the importance of human rights was affirmed though the establishment of the Human Rights Commission in 1977 "to promote the advancement of human rights in New Zealand in general accordance with the United Nations International Covenants on Human Rights".[38]

Awareness of patient rights also grew in New Zealand's mental health sector. Several inquiries into events at mental hospitals revealed unsatisfactory conditions and at times, failure to provide for basic comfort and safety. A fledgling consumer movement was formed in the 1970s under the banner

[32] Letter from RFP Perry to B James, 1 November 1985, ABQU 632 W4452 Box 140 30/39 (59408), Archives New Zealand, Wellington.

[33] Letter from MGL Loughnan to the Minister of Health, 19 June 1981, ABQU 632 W4452 Box 140 30/39 (52663), Archives New Zealand, Wellington; Memo from F Hay, n 15.

[34] Brunton W, "Mental Health: The Case of Deinstitutionalisation" in Davis P and Ashton T (eds), *Health and Public Policy in New Zealand* (Oxford University Press, Auckland, 2001) pp 181-200.

[35] Summary of District Inspector/Official Visitor Information, circa January 1982, ABQU 632 W4415 Box 64 30/39 (55191), Archives New Zealand, Wellington.

[36] Cossley N, *Contesting Psychiatry: Social Movements in Mental Health* (Routledge, Oxon, 2006).

[37] Harris A, *Hikoi: Forty Years of Protest* (Huia, Wellington, 2004).

[38] *Human Rights Commission Act 1977* (NZ), Preamble.

of "Psychiatric Survivors" and other organisations such as the Mental Health Foundation of New Zealand lobbied for greater safeguards for patients' rights.[39] In 1979, in response to an inquiry by the Ombudsman, the Department of Health admitted that most psychiatric hospitals "took no special steps to ensure that patients are aware of their right of access to the District Inspector".[40] For the next three years, the Department attempted to improve the way in which hospitals notified patients of the existence of DIs and OVs, instructing them to produce information pamphlets for new patients, and place fliers on ward notice boards.[41]

With the increased visibility of their roles, and higher expectations of availability and responsiveness, DIs began to question the voluntary nature of the job. Some complained that while they were pleased to fulfil the role, they had business costs they needed to cover.[42] Basil James, the new Director for Mental Health, took a very different stand to his predecessor: rather than worrying about the risk to independence, he told DIs that "payment could be viewed as a reflection of the seriousness with which the office of District Inspector was held".[43] In 1983, after lengthy discussions with hospital boards and DIs, the Department introduced remuneration for DIs. This was justified because, "[e]vents this year have made it very clear that there is a continuing need to monitor the standard of care in New Zealand's psychiatric hospitals. The District Inspector … is one of the few legislative safeguards available to patients in the mental health system".[44] Remuneration, the Department claimed, would allow DIs to increase the time spent visiting hospitals and investigating patient queries.

"Events this year" referred to the Gallen Inquiry which revealed serious deficits in the care of patients at Oakley Hospital, an Auckland psychiatric hospital catering for forensic male patients. The Gallen Report released in January 1983 noted, among other things, that patients lacked access to external support and advocacy. It recommended that at least one OV should be appointed for Oakley Hospital as soon as possible.[45] It appears that Justice Gallen's findings stirred the Department of Health into action.[46] Shortly before release of the report, James invited all hospital boards to reinstate the OV role. The modern OV, he claimed, was not to merely "take a sympathetic and philanthropic interest in the welfare of the patients and the general conditions of the hospital" as their predecessors had done but they were to be a "community watchdog" who would advocate for patients and "safeguard against the dangers of institutionalisation". In this era of increased awareness of patient rights, he claimed that the community demanded a robust system of external scrutiny of psychiatric hospitals.[47]

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[39] See, for example, Task Force on Revision of Mental Health Legislation, *Towards Mental Health Law Reform* (Mental Health Foundation of New Zealand, Auckland, 1983); The Wellington Patients Association, *Rights and Wrongs: A Report of a Seminar on the Rights of Psychiatric Patients* (Wellington Patients Association, Wellington, 1980).

[40] Letter from RA Barker (Deputy Director-General of Health) to Hospital Board Chief Executives, 29 November 1979, ABQU 632 W4452 Box 140 30/39 (52663), Archives New Zealand, Wellington.

[41] Circular letter from SWP Mirams to Medical Superintendents, 16 July 1979, ABQU 632 W4452 Box 140 30/39 (52663), Archives New Zealand, Wellington; Letter from HJH Hiddlestone (Director-General of Health) to LJ Castle (Office of Ombudsman), 30 July 1982, ABQU 632 W4452 Box 140 30/39 (55191), Archives New Zealand, Wellington.

[42] Letter from MGL Loughan, n 33; Letter from MJ Behrens to the Director-General of Health, 8 September 1981, ABQU 632 W4452 Box 140 30/39 (52663), Archives New Zealand, Wellington.

[43] Summary of Duties and Powers of a District Inspector of Mental Hospitals, 26 March 1982, p 5, ABQU 632 W4415 Box 64 30/39 (55191), Archives New Zealand, Wellington.

[44] New Policy Proposal – New Initiative, 1983, ABQU 632 W4415 Box 64 30/39 (55191), Archives New Zealand, Wellington.

[45] Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, n 29.

[46] Dawson, n 5 at 3.

[47] Circular letter from B James to Hospital Boards Chief Executives, 15 November 1982, ABQU 632 W4452 Box 64 30/39 (55191), Archives New Zealand, Wellington.

REVIEW OF THE MENTAL HEALTH ACT 1969: RIGHTS, ADVOCACY AND PROFESSIONALISATION

Just one month after release of the Gallen Report, the Department of Health publicly launched a review of the *Mental Health Act 1969*. Its "Mental Health Act Review: Position Paper" optimistically claimed that the review would "reflect new directions in psychiatric practice and contemporary community attitudes".[48] By this time, the Department had begun consultation with "relevant individuals and organisations", reviewed legislation in other countries, and held departmental discussions.[49] The paper hoped that amendments to the Act would "be ready for presentation in the 1984 legislative year".[50] This was not to be the case partly because of the controversial nature of the legislation, partly because of the broader context of the changing focus on rights and legislative changes taking place in New Zealand around these issues, and partly because of the interest of individuals and organisations wishing to influence the new legislation.[51]

Initially the focus on protection of rights came not from the Department's Mental Health Review Working Party but from the Taskforce on Revision of Mental Health Legislation, a coalition of the Legal Information Service and the Mental Health Foundation. The Taskforce's comprehensive 1983 report, *Towards Mental Health Law Reform*, informed public debate and influenced government thinking on the issue.[52] In 1984, the Department of Health's second publication on the matter, *Review of the Mental Health Act 1969: Discussion Papers*, devoted a whole chapter to patients' rights with specific comment on safeguards and avenues for complaint.[53] The Working Party believed that new review tribunals would allow for patients' rights to be upheld, particularly in relation to reviewing legal status. In other matters, it favoured continuation and strengthening of the DI and OV roles. It believed that "safeguards already exist, though ways of improving them and making them better known should be considered". Suggested improvements included establishing avenues for complaint, ensuring patients were given information on their rights (with a suggestion that hospitals clearly displayed these) and the development of guidelines and codes of practice for staff.[54]

Advocacy was a contentious issue throughout the review. The Working Party claimed "that because of the roles of Official Visitors and District Inspectors, there is no need for an additional system of independent advocacy".[55] The Taskforce disagreed. It favoured a "wholly different approach" to patient rights which included an independent system of advocacy.[56] The Taskforce's position was influenced by recent controversy surrounding the reinstatement of the OV role in mental hospitals. In keeping with James' vision of a stronger watchdog function for the OV, mental health reformers had lobbied for better cultural and community representation. However, an attempt by the Auckland Hospital Board to nominate people from culturally and economically diverse backgrounds had been stymied by Aussie Malcolm, the National Government's Minister of Health. Malcolm refused to accept nominations that included "radical activists".[57] Instead, he unilaterally appointed four Pakeha from the Auckland's North Shore, claiming they were "solid, middle-of-the-road citizens"

[48] New Zealand Department of Health, "Mental Health Act Review: Position Paper (1983)" in Mental Health Act Review Working Party, *Review of the Mental Health Act 1969: Discussion Papers* (Department of Health, Wellington, 1984) Appendix 1, p 132.

[49] New Zealand Department of Health, n 48, p 122.

[50] New Zealand Department of Health, n 48, p 122.

[51] New Zealand Department of Health, n 48, p 132.

[52] Task Force on Revision of Mental Health Legislation, n 39, p iv.

[53] Mental Health Act Review Working Party, n 48.

[54] Mental Health Act Review Working Party, n 48, p 86.

[55] Mental Health Act Review Working Party, n 48, p 86.

[56] Full Submission of the Taskforce on Revision of Mental Health Legislation, April 1985, p 23, ABKZ W4149 Box 123, Pt 1, 7/1/28, Archives New Zealand, Wellington.

[57] Letter from A Malcolm (Minister of Health) to FA Gordon, 16 November 1983, ABQU 632 W4415 Box 65 30/39 (57027), Archives New Zealand, Wellington.

who would "do a better job than the people originally suggested".[58] The Auckland situation elicited a wave of protest about the lack of Polynesian representation.[59] Although supportive of a continuing role for OVs, the Taskforce questioned their ability to provide advocacy and claimed they were not representative of the cultural diversity of people held under the committal.[60]

The question of who should provide advocacy continued to be a point of difference between the Taskforce and the Working Party. The Taskforce continued to lobby for an independent mental health advocacy service but the Working Party feared that an advocate may act in "an unnecessarily adversarial way".[61] The Taskforce, however, reiterated the need for paid, trained advocates available to patients on a day-to-day basis, arguing that, patients should not be "left to complain to unpaid or part-time officials who have no powers to direct hospital compliance".[62] It also believed that DIs and OVs should be adequately trained and remunerated for their work.

During the process of review, pressure was brought to bear to professionalise the DI and OV roles through payment and support. In many people's minds, remuneration came to signify the seriousness of the roles and was no longer perceived to be an impediment to independence. Although the Department had agreed to payment for DIs, it never seriously considered the same for OVs.[63] As one OV commented, discussions of payment always finished with "inconclusive embarrassment".[64] Other measures to strengthen the roles, such as regular meetings and rudimentary orientation, were introduced during the 1980s.[65] These measures reflected the increased focus on patient rights and the increasing expectations of a more rigorous watchdog role within the new Act. In announcing the first ever meeting of DIs, the Director-General of Health noted that "[t]here has been an important groundswell of feeling in the community relating to the whole issue of civil rights, but especially as they relate to psychiatric patients".[66]

The *Mental Health Bill 1987* (NZ) was introduced to Parliament on 8 December 1987 by the Labour Government's Minister of Health, David Caygill. It received a second reading on 12 March 1992 and a third reading on 2 June 1992 under the National Government. The long gap between the first and second readings arose because the Bill went to the Social Services Committee which received oral and written submissions over a two-year period. This Committee reported back to the House in November 1989, but the continuing amount of correspondence regarding the Bill meant the then Minster of Health, Helen Clark, asked the Department of Health to establish a review group to consider the issues raised. This group produced considerations and created a supplementary order paper to the Bill. The group mostly considered matters to do with advocacy, including the DI role.[67] By this time, patient rights and advocacy had assumed a new significance in New Zealand because of the Cartwright Inquiry and Report. The 1988 Report into cervical cancer treatment and research at National Women's Hospital recommended the establishment of patient advocates and the creation of a

[58] *New Zealand Herald*, 26 October 1983, ABQU 632 W4415 Box 65 30/39 (57027), Archives New Zealand, Wellington.

[59] For example, Letter from R Walker (Chairman, Auckland District Maori Council) to A Malcolm, 17 October 1983; Letter from DL Antcliff to A Malcolm, 22 November 1983; Letter from S Healy, OP to A Malcolm, 26 October 1983, ABQU 632 W4415 Box 65 30/39 (57027), Archives New Zealand, Wellington.

[60] Taskforce on Revision of Mental Health Legislation, n 56, p 24.

[61] Mental Health Act Review Working Party, n 48, p 92.

[62] Taskforce on Revision of Mental Health Legislation, n 56, p 23.

[63] Mental Health Act Review Working Party, n 48, p 93.

[64] Letter from EJ Laird to B James, 18 June 1985, ABQU, W4452, 632, Box 140, 30/39 (59408), Archives New Zealand, Wellington.

[65] Guidelines for Official Visitors, December 1983, ABQU 632 W4415 Box 65 30/39 (57027), Archives New Zealand, Wellington; Letter from RFP Perry to B James, 8 August 1988, ABQU 632 W4452 Box 1738 355-2-9 (64468), Archives New Zealand, Wellington.

[66] Memo from Director-General's Meeting, 12 February 1982, ABQU 632 W4452 64/30/39 (55191), Archives New Zealand, Wellington.

[67] New Zealand Parliament, *Parliamentary Debates* (12 March 1992) (O'Regan K – second reading of *Mental Health Bill*).

Health Commissioner under the *Human Rights Commission Act 1977* (NZ).[68] Calls for mental health advocates were reinforced by the appointment of a patient advocate at Kingseat Hospital – a move prompted by the Cartwright Inquiry.[69] Several submissions to the Social Services Select Committee referred to the Cartwright Report and urged the government again to establish a paid advocacy service available to psychiatric patients.[70]

Even at this late stage of the *Mental Health Bill's* progress, the government resisted the appointment of paid advocates for mental health, preferring instead to rely on DIs and OVs. In Parliament, Katherine O'Regan, Member of Parliament for Waipa questioned the Minister of Health, whether patient advocates were being considered for psychiatric hospitals "as advocated in many submissions on the Mental Health Bill?"[71] Caygill's response was that the appointment of patient advocates was intended for general hospitals only and that "there is a type of advocacy system in psychiatric hospitals at present – namely, by Official Visitors and District Inspectors". However, Caygill explained that "[c]onsideration is being given to whether there should be some integration between the systems, or, alternatively, whether the District Inspector or the Official Visitor system provides a suitable model that could be translated to general hospitals".[72] The crossing over of DIs and OVs to general hospitals did not occur. However, the question of whether the system of DIs and/or OVs fulfilled the role of an advocate was contested up until the passing of the 1992 Act.

As the *Mental Health (CAT) Act 1992* was about to be passed, the question of advocacy remained unclear. In 1990, Cabinet had agreed to establish a national patient advocacy system for the whole health system and to integrate the role of OVs into it within 12 months. District Inspectors would remain in the psychiatric system, but their eventual integration in the advocacy system was expected.[73] The Ministry of Health considered deferring the appointment of OVs, but this was thought to be potentially expensive because in their absence, DIs might be drawn into patients' "lifestyle issues" which were considered more appropriately handled by someone in a voluntary role.[74] In any event, OVs and DIs were not integrated into the national patient advocacy system.

Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ)

The DI role, with its prerequisite for legal qualification, was retained in the *Mental Health (CAT) Act 1992*. In this respect, it is unique internationally as a watchdog of mental health rights. The OV role was also retained but at the time of publication, 14 years after the Act was passed, no OVs have been appointed. Some expectations of the roles have carried through from the 19th century with little change. District Inspectors are still appointed by the Minister of Health and are expected to be independent of mental health services. They are still required to undertake regular inspections of mental health institutions with the right to visit at any time of day or night. The DI's authority to investigate complaints and undertake inquiries has not changed substantially from that of their predecessors.

Some significant changes were, however, introduced under the Act. District Inspectors are no longer responsible for informal patients because the legislation only applies to people detained under

[68] Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and Other Related Matters, *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and Other Related Matters* (Cartwright Report) (The Committee, Auckland, 1988) pp 173, 174-175, 213.

[69] "Mental Patients get Legal Advocate", *The Dominion* (6 October 1988) p 10.

[70] Submissions to the Social Services Select Committee on the *Mental Health Bill 1987* (NZ): New Zealand Psychological Society Inc (29 February 1988); Psychiatric patients (community-based) (28 February 1988); Wellington Women's Health Collective (3 March 1988), AANH 7505 W3484 Box 1, Archives New Zealand, Wellington.

[71] New Zealand Parliament, *Parliamentary Debates* (15 November 1988) (O'Regan K – Questions on Notice: Patient Advocates).

[72] New Zealand Parliament, *Parliamentary Debates* (15 November 1988) (Caygill D – Questions on Notice: Patient Advocates).

[73] Letter from T Johns (Manager Mental Health Policy) to R Ritchie (Acting Manager Policy), 14 May 1990, ABQU 632 W4452 Box 1739 355-2-9 (77441), Archives New Zealand, Wellington.

[74] District Inspectors, Official Visitors and Review Tribunals under the Mental Health (Compulsory Assessment and Treatment) Act 1992, circa 1991-1992, ABQU 632 W4452 Box 1739 355-2-9 (77441), Archives New Zealand, Wellington.

the Act. In other respects, the requirements of the DI role are now much more intensive. District Inspectors are required to meet every patient brought under the Act to check their legal documentation and explain their rights, in particular their entitlement to a review of legal status. The DI now has the power to inquire into alleged breaches of a positive list of patient rights. These responsibilities and powers apply to people in the community as well as those assessed and treated in hospital. Each time a patient's legal status changes, the DI is sent a copy of the certificate. District Inspectors are legally required to visit every hospital or inpatient service at least monthly, and each outpatient service at least three monthly.

In June 1992, as the Act was being enacted, DIs met in Wellington. They were in general agreement that their new role would be something akin to a "legal ombudsman" rather than an advocate.[75] Aware of the increased workload under the new Act, they discussed their ability to provide a service for patients in the community and expressed concern about the lack of representation for informal patients. A recent study found these concerns are still present today. District Inspectors are much busier than in the past and tend to focus by necessity, more on the needs of patients in the acute inpatient settings than in the community. They still reject the label of "advocate". Rather, DIs view their role as that of an ombudsman who acts as a legal watchdog of patient rights and facilitates access to legal representation and advocacy.[76]

Conclusion

This investigation into the historical background of the New Zealand DI role has shown the importance of understanding the social and political context of legal reform. Debates about whether to include the DI and OV in the *Mental Health (CAT) Act 1992* occurred within the context of a raised awareness of civil rights, concerns about patient rights, and public disquiet about conditions in mental hospitals. Calls for improved advocacy in the health system contributed to demands for professionalisation of the roles. These discussions, however, did not occur within an historical vacuum. The DI and OV positions were longstanding. What the legal reformers of the 1970s and 1980s had to consider was whether to continue these roles in a post-institutional environment.

When there is social, political or legislative change, the past is often portrayed as inadequate for addressing contemporary concerns. As Dawson and Gledhill recently claimed, the "new Act ushered in reforms that were necessary to address two major requirements of contemporary mental health law", that of respect for human rights and the ability to meet patient needs in a deinstitutionalised environment.[77] It appears that the extended role of the DI under the *Mental Health (CAT) Act 1992* has allowed DIs to meet these requirements in a manner that would not previously have been possible. This article has illustrated that concerns about the loss of liberty through mental health detainment stretches back to at least the 19th century. Policy-makers and mental health administrators of the 19th and early 20th centuries may not have couched their concerns in the language of human rights, but they established systems and roles designed to mitigate the dangers of institutional detainment. This history of New Zealand's DI and OV roles illustrates that the context and language may have changed but recognition of the need for watchdogs to protect mental health patients is not new.

[75] Minutes of District Inspectors' National Meeting, 19 June 1992, ABQU 632 W4452 Box 1739 355-2-9 (77441), Archives New Zealand, Wellington.

[76] Thom K and Prebble K, "The Watchdogs of Patient Rights: The Role of the District Inspectors" in Dawson and Gledhill, n 2, pp 131-146.

[77] Dawson and Gledhill, n 2, p 19.