REPORT TO THE MINISTRY OF HEALTH ON THE OFFICES OF THE DIRECTOR OF MENTAL HEALTH, DISTRICT INSPECTOR & DIRECTOR OF AREA MENTAL HEALTH SERVICES

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Executive Summary

1. This Report began as a stand alone report on the statutory roles and functions of the Director of Mental Health [Director]. It links directly with two earlier reports – on District Inspectors [DIs] and Directors of Area Mental Health Services [DAMHS] — written for the Ministry this year. It seemed sensible to combine all these reports into this one, modifying the earlier two reports to take account of the recommendations relating to the Director. Accordingly, this executive summary is restricted to the review of the Directorship and its implications for DIs and DAMHS. The modified executive summaries to the earlier reports appear as Appendices 2 and 3 at the end of this Report.

2. The Director is appointed under the State Sector Act 1988 as a statutorily recognised officer of the Ministry of Health, responsible for the general administration of the Mental Health (Compulsory Assessment & Treatment) Act 1992. The Director has a limited number of functions under that Act, which fall into three broad groups:

(a) Powers and duties relating to special and restricted patients;

(b) Powers of inspection and inquiry, and responsibilities in relation to District Inspectors [DIs];

(c) Administration of the Act, including providing advice and support to the Directors of Area Mental Health Services [DAMHS].

3. Currently the person who holds the statutory office of Director is also the Chief Psychiatric Advisor to the Ministry. The roles are different and also potentially conflicting, and rolling them together in one person does not aid transparency or accountability. This bundling of roles in the one person is undesirable. The bundling of roles can be overcome by separating the roles of statutory Director and Chief Psychiatric Advisor, and retaining both in separate people in the Ministry. However, an examination of the limited number of statutory functions performed by the Director discloses, in my view, that the Directorship is no longer necessary. The office does not sit comfortably with recent changes in the mental health sector, the broader health reforms or impending changes in the Ministry of Health. It appears to be a hangover from

an earlier time when things were "directed" from the centre in an operational sense. The abolition of the Directorship is recommended. This will allow the Chief Psychiatric Advisor and support staff in the Ministry to focus exclusively on contributing to the formulation of strategic policy advice, ministerial servicing and so–called "reserve" monitoring of the mental health sector; without the distraction of operational issues.

4. The necessary and justifiable regulatory functions carried on presently by or under the control of the Director should be redistributed as follows:

(a) decision–making in relation to special and restricted patients should be transferred, as far as administratively possible, to a specially constituted expert Review Board;

(b) DIs, who report presently each month to the Director, should be completely independent of the Ministry and established either as stand alone Mental Health Ombudsmen or as a separate inspectorate under the umbrella of the Health and Disability Commissioner;

(c) DAMHS should have stronger contractual and reporting links with the THA.

5. These recommendations, along with others made in this Report, will require legislative change. The pending Mental Health (Compulsory Assessment & Treatment) Amendment Bill, presently on the legislative agenda, provides a vehicle to implement these recommendations as soon as possible. While awaiting legislation, I recommend the immediate separation of the office of Director from the role of Chief Psychiatric Advisor, and that these two positions be held by separate persons in the Ministry.

6. In summary, this Report considers the extent to which the offices of Director, DI and DAMHS provide justifiable and necessary protection for the interests of mentally disordered persons under compulsory treatment orders. This Report endorses the social regulatory roles of the DI and DAMHS in protecting the interests of those persons deprived of their liberty by the State and forced against their will to have treatment in order to protect themselves or others from serious danger. These regulatory functions should not be exercised

by the funder. The Director has been the point of contact between the Ministry and DIs and DAMHS, but, for the reasons elaborated upon in the Report, the office of Director is no longer necessary or justifiable.

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1.0 Introduction

1.1 This Report was prepared under contract with the Ministry of Health. The original terms of report were to examine the roles and functions of the Director of Mental Health under the Mental Health (Compulsory Assessment & Treatment) Act 1992 [hereafter referred to as the 1992 Act or the Act]. Over nearly a month in August/September I consulted with numerous people both within and outside the Ministry. A list of the persons consulted appears in Appendix 4. Nonetheless, of necessity, I have had to be selective so there may be some groups or significant opinions I did not hear.

1.2 The initial stimulus for this Report was the work done by the Steering Group and the regulatory framework review. The Report of the Steering Group on *Implementing the Coalition Agreement on Health* (30 May 1997) foreshadowed, in the context of Ministry leadership through regulation, the need for further development on "mental health and the role of the Director" (p. 45). The Director–General of Health [DGH] is contractually bound to the Minister to progress that work in this key result area.

1.3 This Report is also the culmination of two other Reports I have completed for the Ministry this year. The first, dated 20 May 1997, entitled *Report to the Ministry of Health on District Inspectors* [hereafter referred to as *DI Report*] has been sent to the Minister of Health and discussed in the sector, and in part acted upon already. The second Report, dated 22 July 1997, entitled *Report to the Ministry of Health on Directors of Area Mental Health Services* [hereafter referred to as *DAMHS Report*] has been discussed within the Ministry but was overtaken by this Report. Both of these Reports necessarily assumed the continued existence of the statutory office of Director of Mental Health [hereafter referred to as the Director] and a Ministry configured as it has been since the 1992 Act came into force. Imminent changes within the Ministry require the offices of District Inspectors [DIs] and the Directors of Area Mental Health Services [DAMHS] to be looked at again in the light of the recommendations made in relation to the Director.

1.4 This Report is divided into four parts: Part A concerns the role and functions of the Director; Part B concerns the role and accountability of DIs (which is a modified version of my earlier Report, taking account of the recommendations in relation to the Director); Part C concerns the role and accountability of DAMHS (which is a modified version of my earlier Report on the topic, again taking account of the recommendations in relation to the Director); and Part D contains the conclusion.

PART A: The Role and Functions of the Director of Mental Health

2.0 Changes within the Ministry and the Mental Health Sector

2.1 It would be unwise, in my view, to examine the statutory roles and functions of the office of Director in isolation from impending changes in the broader Ministry context. This Report comes amid a period of significant reflection on the role of the Ministry. The interrelationship of the three P's – policy, purchasing and provision – is being rethought in the wake of the Coalition Agreement and the establishment of the Transitional Health Authority [THA]. I am informed that the focus of the Ministry in future will be on: (1) strategic policy, (2) such regulatory activity as is justifiable and which cannot be better performed elsewhere or by superior mechanisms, (3) monitoring of the THA and so–called "reserve" monitoring of the provider sector, and (4) Ministerial servicing. Under this schema operational policy will go into the THA, and staff will be deployed according to function. No doubt, the extent of the shift in terms of resources from Ministry to THA will turn, in part at least, on the ability to cleave cleanly strategic and operational policy, and sensible division of monitoring functions. I am informed that the Chief Advisors in the Ministry will assume even greater significance in terms of feeding information and advice into the performance of the roles just described. This Report assumes the presence of a full–time Chief Psychiatric Advisor in the Ministry (however described) with a support team adequate to the functions to be performed.

2.2 There seems a fair measure of agreement among the people I consulted that the funder (THA) should not discharge regulatory functions, and this seems to me very sound in principle. Necessary regulation is a key Government responsibility and should be discharged outside the funding body. The assumption by a national funding body of a regulatory responsibility for a service area which it funds will lead inevitably to a conflict of interest. The pressure over time for funding imperatives to overwhelm regulatory responsibilities would be strong and difficult to resist.

2.3 Within the context of these foreshadowed Ministry–wide changes has to be set the specific challenges relating to mental health identified in the Mason Report (*Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain Mental Health Services* (May 1996)). Part of the Government's response to that Report is the establishment of the Mental Health Commission [MHC], which is fully operational already and only awaits the imminent enactment of its own statutory mandate. The MHC is a new player in the mental health sector, with the statutory tasks of watchdog and ministerial adviser on the achievement of the goals set out in the National Mental Health Strategy. At a time of a changing relationship between the Ministry and the THA, the establishment of the MHC injects a new set of relationships to be managed across the mental health sector.

2.4 Moreover, the 1992 Act antedated the health reforms ushered in by the Health and Disability Services Act 1993. The development work on new mental health legislation began in earnest in the early 1980s and the 1992 Act was the culmination of that long process of policy development. There is a view, strongly held in some quarters, that at least some of the statutory responsibilities and accountabilities of the Director and other appointees (namely DIs and DAMHS) are in conflict with the business imperatives and accountability structure laid down for Crown Health Enterprises (CHEs). I refer to these concerns in paras 31.5 and 37.3.

3.0 The Qualifications and Appointment of the Director

3.1 The Director is appointed under the State Sector Act 1988 as a statutorily recognised officer of the Department of Health (s. 91(1)). The Director is said in s. 91(1) to "be responsible for the general administration of the [1992] Act" and operates under the direction of the Minister and the Director–General of Health [DGH]. Provision is made for the appointment of a Deputy Director, who is under the control of the Director and performs such tasks as the Director requires (s. 91(1)(b)). Extensive provision is made for delegation by the Director to the Deputy Director and others in the Ministry

(s. 91(2)–(6)). In addition, the DGH may perform any of the statutory powers, duties or functions of the Director (s. 91(7)).

3.2 No qualification is stipulated in the Act as necessary for appointment as Director or Deputy Director. Currently both the Director (Dr Janice Wilson) and the Deputy Director (Dr Nick Judson) are psychiatrists. In her capacity as Director, Dr Wilson has been directly responsible to the DGH (as stated in s. 91(1)) but I understand the DGH is in the process of delegating that responsibility to the General Manager, Implementation (currently Peter Hughes).

4.0 A Multiplicity of Roles

4.1 Over time a number of roles have coalesced in the person who is the Director of Mental Health. At the present time there appear to be at least four sets of functions/roles/responsibilities that sit together in the person of the Director. There is some overlap but it aids my task to separate them out as follows:

1. The "pure" statutory functions of the Director;
2. The role of Chief Psychiatric Advisor to the Ministry;
3. Member of the Mental Health Section of the Ministry;
4. Leader in the psychiatric profession.

4.2 My primary concern in this Report is to address the statutory office of Director and the functions discharged under the statute. However, the office of Director has a long history and its present functions can only be properly understood against that backdrop. The influence and mana of the Director within the psychiatric profession and the mental health sector clearly transcends the limited number of "pure" statutory functions exercised under the Act and reflects the historical importance of the office and the considerable talents of the past and present holders of the office. Amongst other things, the Director symbolises leadership in the centralised Ministry. It is necessary to

appreciate the historical and symbolic importance of the office in considering the particular statutory functions.

4.3 The precise title "Director of Mental Health" derives from the 1992 Act but some such, similarly named, central functionary has been a feature of the mental health scene since the mid–1870s. As Warwick Brunton has pointed out, the Inspector of the new national Lunatic Asylums Department set up in 1876 discharged a number of functions: "He was required to see that the various provisions of the law were carried out, to report on the state of asylums and their inmates, and to advise on and implement Government policy which promoted the care, proper treatment, and supervision of lunatics ... [This] bureaucratic apparatus of lunacy become the principal source of policy advice and service development" ("Colonies for the Mind: The Historical Context of Services for Forensic Psychiatry in New Zealand" in W. Brookbanks (ed.), *Psychiatry and the Law: Clinical and Legal Issues* (Brookers, Wellington, 1996) pp. 3, 9). One can see from this that the bundling of policy, management and operational aspects has a long pedigree in New Zealand. But the environment has changed enormously in recent times. Gone are the days, so well chronicled by Brunton, of tight autocratic control from the centre over a limited number of mental hospitals. The trend to deinstitutionalization, the demise of the Department of Health, the separation of Ministry (policy/regulation), RHAs/THA (purchaser), CHEs/NGO (providers), and the recent wave of human rights consciousness have had a huge impact. The question – what role remains for the Director? – is what this Part of this Report is about.

4.4 The bulk of the Director's time is devoted to the performance of her contractual duty as Chief Psychiatric Advisor to the Ministry. In this role the Director is on a par with the other Chief Advisors. In this capacity the Director is responsible to the General Manager, Implementation (currently Peter Hughes). As noted above in para. 3.2, this is the same person who is taking over responsibility for the discharge of the statutory functions by the Director.

4.5 Some might question teasing out in para. 4.1 membership of the Mental Health Section of the Ministry [hereafter referred to as MHS] from the role of Chief Psychiatric Advisor but doing so casts light on the Director's role and how management changes have altered it. Prior to 1990 I am told the Director combined the roles of "statutory" Director, Chief Psychiatric Advisor and Manager of the Mental Health Division (as the MHS was then called, and which was smaller then than the MHS currently is). The departure of the Director of the Mental Hospitals Division (Dr Basil James) saw the roles of Director and Manager separated and filled by Dr Thakshan Fernando and Mr Tony Johns, respectively. This separation has continued under the 1992 Act but, due to a number of factors beyond anyone's control, for significant periods the Director of Mental Health (by then Dr Janice Wilson) was obliged to manage the MHS in addition to her other functions. There is now more managerial stability. This, in turn, raises the issue of the responsibilities of the Manager and Director for policy formation, where each sits in line management terms for the various functions performed by each, and how work is allocated within the MHS. These matters are taken up in paras 10.1–10.2.

5.0 The "Pure" Statutory Functions of the Director

5.1 Appendix 1 contains a list of the statutory references to the office of Director in the 1992 Act. Despite the large number of such references, the functions and powers of the Director fall into three broad groups:

(1) Powers and duties relating to special and restricted patients;
(2) Powers of inspection and inquiry, and responsibilities in relation to the District Inspectors [DIs];
(3) The administration of the Act, including the role of formulating guidelines and providing advice and support to Directors of Area Mental Health Services [DAMHS].

Most of these powers and functions were carried forward from the Mental Health Act 1969, although the changes wrought by the 1992 Act certainly

increased the demands on the Director, as was the case with everyone else in the mental health sector.

5.2 In line with the Ministry's regulatory framework project I propose below to describe briefly these grouped functions and to inquire as to the continued justification for each and, if justified, to consider whether they should continue to be exercised by, or under the control of, a statutory Director. The primary justification for social regulation in the mental health field is the extraordinary power, unique to the State, to lawfully deprive mentally ill persons of their liberty in order to administer treatment against their will. It is in this regulatory light I will examine these groups of functions.

6.0 Special and Restricted Patients

6.1 The majority of statutory references to the office of Director relate to special and restricted patients. By far the larger group is that of special patients, estimated to number approximately 100 at any time. Broadly speaking, this group comprises (1) persons committed to a psychiatric hospital by a Court having being found to be under a disability or acquitted on the ground of insanity (approximately 75–80), and (2) offenders transferred from prison to hospital having been found to suffer from mental illness while serving a prison term (approximately 15–20). Restricted patients number less than a handful. At present, the Deputy Director (Dr Nick Judson), who has expertise in forensic psychiatry, exercises these powers under delegated authority from the Director. An estimate of the time taken up in discharging this bundle of functions is approximately half a day a week. In addition, I am informed that other members of the MHS provide assistance the equivalent to 2–3 days a week for one person.

6.2 There is no doubting the need for regulation and control of these categories of patients and of necessity this needs to be orchestrated centrally. I am not an expert on mental health law or forensic psychiatry but I have consulted persons who are, and the unanimous view of those both inside and outside the Ministry is that the necessary powers in relation to special and

restricted patients could profitably be transferred to a *specially* constituted Review Board. I have underlined the requirement for a specially constituted Board to deal with these issues, for these decisions call for expert, independent medico–legal evaluation. There is precedent overseas for such a move. I do not have the expertise to work out the details of that proposal, but I do not doubt that an expert committee could work out the details quickly and satisfactorily. It should be noted that this Board would need to be able to act quickly, e.g. by delegation to an individual Board member, to handle patient transfers between services, between prison and services, and leave approvals. It should be noted that there would not be any lessening of the administrative load on the MHS; indeed it might increase slightly, at least initially.

7.0 Investigation and Inquiry Functions

7.1 The investigation and inquiry functions divide up into those exercised by the Director, directly or indirectly, and those conducted at the initiative of the DIs. In the *DI Report* at paras 21.1–21.6, I considered the inquiry function of the DIs and the inquiry powers potentially available to the Director, the DGH and the Minister. That discussion was directed to the question whether the DIs should retain their relatively unfettered discretion to initiate inquiries under s. 95 of the 1992 Act. I concluded that this power was a valuable adjunct to the DIs' complaint handling jurisdiction and should be retained. It was not necessary there to address the issue of the Director's independent power to direct a DI inquiry, but this issue arises squarely in the context of this Part of the Report. If the office of Director disappears, this power to direct a DI inquiry either will go with it or have to be placed in the hands of someone else. (At present, it should be noted that by virtue of s. 91(1) the DGH can exercise the Director's power to initiate a DI inquiry; although I am not aware of that ever being done.) This is discussed further at para 21.6.

7.2 The thrust of the *DI Report* recommendations was to strengthen the accountability of the DIs by tightening the reporting lines to the Ministry through the Director and developing more of a public service ethic among the

DIs. That Report was written on the assumption that the office of Director was here to stay.

7.3 The Director (and the Deputy Director) read the monthly reports supplied by the 27 or so DIs each month, and approve their bills for payment. The monthly reports can be a valuable source of information as to what is happening at the grass roots of service provision. There is also less formal contact with the Ministry by some of the DIs seeking advice, guidance or passing on concerns. In addition, the Ministry convenes a twice yearly meeting in Wellington of the DIs. The Director also receives the more formal of the s. 95 inquiries initiated by DIs. In very recent times some of these inquiries have been controversial, contested and expensive in terms of time and money. This is true also of the less frequent Director–initiated inquiries, as the recent Paki inquiry illustrates. These high profile inquiries have absorbed enormous amounts of staff time in the MHS. On these occasions the Director's time can be monopolised for days, if not weeks, on end with inquiry business. In less turbulent periods it is estimated that the DI servicing would average a few hours a week, with much of that done by key staff in the MHS other than the Director.

7.4 The inquiry and investigation functions net the Director a significant amount of intelligence about the operation of the Act and the provision of mental health services on the ground. This feeds into the other information the Director receives wearing one or more of her other "hats" (namely, Chief Psychiatric Advisor, MHS member and leader in the sector). The combination of all this information and opinion in one person clearly enhances performance of the Director's many different functions, especially policy formulation and development. There are, however, potential problems in terms of role ambiguity, potential for role conflict, and a consequent lack of transparency and ultimately accountability by rolling these functions together in one person. This issue is addressed below at paras 11.1–11.2. The point to make here as regards the inquiry function is that once seized of any evidence of system failure the Director has no formal power to give effect to any recommendations for change or to otherwise force changes in service delivery. Of course, the

Director uses her considerable powers of persuasion and contacts to try to effect change, but the lack of legal power remains. This legal impotence can place the Director in the invidious position of disappointing the unrealistic expectations of the sector.

8.0 *Responsibility to Administer the Act*

8.1 The last group of powers the Director exercises concerns the statutory responsibility to administer the Act (s. 91(1)). This role carried over from the 1969 Act but the 1992 Act was novel in many respects and it took a long time "to bed in". The Ministry has played, and continues to play, a key role in the provision of advice and assistance relating to the interpretation and application of the legislation. An illustration is the publication earlier this year of the *Guidelines to the Mental Health (Compulsory Assessment & Treatment) Act 1992* (June 1997).

8.2 Under this grouping can be placed the Director's involvement with the Directors of Area Mental Health Services [DAMHS]. The role of DAMHS is addressed in Part C of this Report. Here it suffices to say that the Director and key members of the MHS have both formal and informal contact with DAMHS. As with the DIs the Ministry hosts regular (in this case, quarterly) meetings in Wellington for DAMHS, and they often seek advice from the MHS. The DAMHS had a difficult relationship with the old RHAs, which is improving with the THA. The thrust of the *DAMHS Report* was to strengthen the monitoring and feedback to the THA, as well as to the Ministry via the Director. The Ministry's relationship with the DAMHS is one way in which administration of the Act is monitored.

9.0 *The Director as Capstone on a Regulatory Arch?*

9.1 As the 1992 Act stands at the moment, the DIs and DAMHS each form a base of an arch reaching up to the Ministry via the Director. The regulatory roles of the DIs and DAMHS are complementary. Both are designed to protect

the rights and interests of patients and proposed patients, who have been lawfully deprived of their liberty by the State in order that treatment can be administered against their will. Whereas the DI is the external watchdog of patients' rights under the Act, the DAMHS can be viewed as the internal clinical watchdog of patients' rights and treatment. The justification for these functions by DIs and DAMHS is the same, and it is set out in para 17.1–17.4 and 31.4–31.9 below. So DIs and DAMHS provide checks and safeguards in a system where the human and societal costs of unmanaged risk is potentially large.

9.2 I am convinced of the importance and value of the existing powers and activities of DIs (although some improvements can and should be made, as is made clear in Part B of this Report). While the situation is not so overwhelmingly clear in relation to DAMHS, I have reached the clear view that they perform necessary functions also and consequently that their regulatory role is justifiable. The Director is atop this arch: it is to the Director that the reports and inquiries flow (albeit often handled or read by others in the MHS); it is the Director (again with able assistance) who vets applicants or nominees; and these 'agents' are frequently said to be the Director's (and the Ministry's) eyes and ears on the ground. With the exception of the Director's independent power to direct a DI inquiry, however, it is not obvious to me that in all of this the Director adds significantly to the monitoring and watchdog roles of putting right complaints, vigilantly protecting patients' rights and ensuring adequate treatment in compliance with the Act. As noted above, the Director lacks the formal power to force services to make changes. The benefits of the intelligence and information flows is of more direct relevance to the role of Chief Psychiatric Advisor, but I think those benefits can be captured to the Ministry without necessarily retaining the statutory Directorship. It is envisaged that copies of DI and DAMHS reports will continue to flow to the Chief Psychiatric Advisor.

9.3 I would be perturbed if abolition of the office of Director affected adversely the roles performed by DIs and DAMHS, but I do not envisage that will happen. As noted immediately above, the reports and contacts will flow to

the Ministry via the Chief Psychiatric Advisor, as well as to the THA and (in relation to any DI investigation of a patient's complaint of breach of rights) the provider. In Part B the recommendation is made, in the event that the Directorship is abolished, that the DIs' jurisdiction become independent of the Ministry, either forming a stand alone Mental Health Ombudsmen–type office or coming under the umbrella of the Health and Disability Commissioner (see para. 20.10 below). It is envisaged under Part C that DAMHS reports would go to the THA but be copied to the Ministry via the Chief Psychiatric Advisor (see para. 34.2 below). This flow of information will aid "reserve" monitoring by the Chief Psychiatric Advisor and the support team, and inform strategic policy formation in the Ministry.

10.0 The Director–Manager Division of Responsibilities

10.1 As noted in para. 4.5 above, some issues potentially arise in relation to the division of responsibilities between the Director and MHS Manager (presently Ron Paterson), and their line responsibilities within the Ministry. I should point out that the working relationship between the two seems to be an excellent one and that I am talking about potential, and not actual, difficulties. The Manager is responsible to the Assistant General Manager, Services Policy in the Implementation Group (currently Chris Harrington), whereas the Director is now responsible to the General Manager, Implementation in both her capacity as statutory Director and Chief Psychiatric Advisor (see para. 4.4 above).

10.2 The Manager of the MHS has responsibility for managing the formulation and implementation of mental health policy across that sector, and also has day–to–day managerial responsibility for the administration of the Act. There is considerable overlap in functions here with those of the Director. This is hardly surprising given the presence in the Ministry of a Section devoted to Mental Health. If the relationship was less than the harmonious one which exists at present there could well be difficulties of co–ordination and co–operative endeavour. No doubt such relationship management is required of all the Chief Advisors, but the presence of the statutory powers as Director

12.2 In the event of the Directorship being abolished, the existing functions should be redistributed as follows:

(a) decision–making in relation to special and restricted patients should be transferred to a specially constituted expert Review Tribunal as far as administratively possible;

(b) DIs' jurisdiction to move outside the Ministry to either a stand alone Mental Health Ombudsmen–type office or under the administrative wing of the Health and Disability Commissioner; and

(c) DAMHS will have stronger contractual links with the THA and should remain at arm's length from the Ministry.

Most of these recommendations require statutory amendments. In the meantime a first step along this path would be to separate the Directorship and Chief Psychiatric Advisor roles, and to allocate those duties to different persons within the Ministry. This could, and should, be done as soon as possible.

PART B: The Role and Accountability of District Inspectors

13.0 Introduction

13.1 As indicated in para. 1.3 above, this Part comprises my earlier *DI Report* modified to reflect the discussion and recommendations made in Part A in relation to the Director, and similarly those made in Part C in relation to DAMHS. The terms of report for the *DI Report* were to examine the role and accountability of District Inspectors [DIs], and to make such recommendations as appear necessary. A limited time frame necessitated less than systematic consultation with some DIs, DAMHS, regional offices of the THA, CHE providers of mental health services, and within various parts of the Ministry. A list of the persons consulted appears in Appendix 4. It was not part of my brief to consult with consumers of mental health services or the groups representing their interests, and it would have been difficult to do so within the stipulated time frame. The *DI Report*, reproduced in this Part in a slightly modified form, is a preliminary examination of the role and accountability of DIs. It contains some recommendations and notes a range of views about the performance and utility of DIs.

14.0 The Qualifications and Appointment of District Inspectors

14.1 DIs are required by the 1992 Act to be barristers or solicitors (s. 94(3)). Although these terms are not defined in that Act, it is evident from the Law Practitioners Act 1982 that to be eligible for appointment a DI must be on the roll of barristers and solicitors of the High Court of New Zealand pursuant to the latter Act and practise either as a solicitor or a barrister.

14.2 The requirement of legal training and legal practical experience on the part of DIs is of relatively recent origin. The office of DI in New Zealand can be traced back to the Lunatics Act 1882, and there the only disqualification from appointment was of practising physicians, surgeons and apothecaries

(s. 129). Legal qualification was mentioned first in the Mental Defectives Act 1911, where the Governor was directed to ensure that at least one DI in each District was a barrister or solicitor, unless the Governor considered such qualification unnecessary (s. 41(1)(c)). It was in the Mental Health Act 1969 that the requirement of legal qualification hardened into a prerequisite (s. 5) and this was carried forward into the 1992 Act.

14.3 One point raised by some of the people consulted was whether DIs really needed to be lawyers, and the comment was made that as a group lawyers brought an adversarial cast of mind to the various roles DIs perform. Ideally the qualification for appointment should correlate with the tasks to be performed under the Act (discussed below at para. 17.4) but something should be noted here about the implications of the statutory requirement of legal training and practice. It is clear that as a legal professional the DI is to be independent of the CHE and NGO providers of mental health services to those persons subject to a compulsory treatment order [cto]. This is confirmed by s. 94(2), which provides that no one can be appointed as a DI who is an officer, member or employee of a hospital or service in that area. Obviously the requirement of legal training, rather than say clinical or managerial expertise, suggests strongly limits to the role of DIs in clinical practice or management issues. That said, the involvement of an independent professional person outside the medical, nursing and managerial professions might be seen as a valuable counterweight to undue deference within the hierarchies of the various mental health disciplines.

14.4 It is clearly envisaged that DI work will be part–time and conducted in conjunction with an active practice. DIs' workload under the 1969 Act was slight until the mid–1980s but grew from then onwards, and rose again with the advent of the new Act in 1992. This issue of workload is taken up below at para. 16.1 but its relevance here is to the independence of the DIs. A part–time job fitted in with an otherwise busy legal practice is one that can be discharged without significant dislocation of other work and lost without significantly impacting on income or the practice.

14.5 DIs are appointed by the Minister and paid by the Ministry, upon approval of monthly accounts rendered to the Director. Some DIs believe payment via the Ministry compromises their independence in an unacceptable way, and have advocated payment out of the Consolidated Fund. One long–time DI wrote that the person who holds "the purse strings is the Minister of Health, the very person ultimately responsible for the performance of mental health services" (P. Treadwell, "The Old and the New: Recollections of a Former Inspector"[1996] *Mental Health and the Law Bulletin* 14, 16). This is a matter which will be returned to in para. 20.9 when considering the accountability of DIs.

14.6 As I understand the process of appointment, the District Law Society in the area is consulted and either supplies a list of the names of persons with an interest and expertise in mental health law or nominates a particular suitably qualified person. The Director then calls for detailed curricula vitae and references. The selection used to be done on those papers but last year an interview component was added, and this is a valuable improvement. The Director recommends a name to the Minister. With the exception of the first round of appointments under the new Act which went through the Cabinet Appointments and Honours Committee, subsequent appointments have not had Cabinet approval as there is no requirement or necessity to do so. It is worth noting here that many of the DIs appointed under the 1992 Act were "rolled over" from the former regime under the 1969 Act.

14.7 The term of appointment is for three years and can be renewed (s. 94(3)). There is no specific power in the Act to remove a DI during this term, which has lead to the erroneous inference that there is no power to do so. The power comes from s. 25(h) of the Acts Interpretation Act 1924, which provides as follows: unless the context otherwise requires (which the 1992 Act does not), words authorising the appointment of "any public officer or functionary" include the power to remove, suspend, reappoint or to replace with another at the discretion of the person in whom the power of appointment is vested (in this instance, the Minister). It is likely that cause would have to be shown and procedural fairness accorded any DI suspended or removed, but

the point to stress is that there is power to do so if the circumstances warrant it. It would be desirable, however, to have all the relevant powers in the 1992 Act and accordingly I recommend that s. 94 be amended to include the power to remove, suspend or replace DIs during the three year term.

14.8 Most of the DIs appointed under the 1992 Act came up for reappointment last year and all were reappointed. I understand there was some evaluation of each DI's performance and some form of consultation with the DAMHS and, if details were provided by the DIs, nominated consumer groups. There is an issue whether service providers and consumers (through representative groups) should be consulted in this process in a more systematic way. It is clear from my consultations that the single biggest determinant of how successful a DI will be is the quality and skills of the individual appointed. A wide range of skills is required, including: good judgement; wisdom and an understanding of human frailty; the ability to put people at their ease and to communicate effectively with patients from a variety of backgrounds and staff; cultural sensitivity; a thorough knowledge of the mental health legislation and how it works, and its interaction with cognate legislation such as the Health and Disability Services Act, the Crimes Act, Hospitals Act, Bill of Rights Act and the Code of Consumers' Rights; liaison with lawyers representing patients; an ability to foster good working relationships with staff and management while retaining objective detachment; a willingness to educate others on the requirements of the law; and the desire and ability to uphold the rights of the patient in the interests of the patient and society. This a pretty tall order and, as we will see, the skills required vary somewhat with the different tasks undertaken by the DIs. Understandably some DIs are more comfortable speaking with patients and explaining their rights to them than they are conducting a formal inquiry into a controversial matter, and vice–versa. [Unless the contrary is stated or the context otherwise requires, I use "patient" in this report to include proposed patient.]

14.9 I recommend that the Ministry examine the appointment and reappointment processes for DIs, giving consideration to how to identify the best possible candidates for appointment and how to fairly and appropriately

gather the views of user groups (including patients, providers, Family Court judges and mental health lawyers). Most of the present appointees will come up for reappointment again in 1999. It would be opportune after 6 years experience under the new Act and in the light of the recommendations in this Part of this Report to open up the appointments process and to ask the existing DIs to reapply along with any other applicants. Consideration should be given to advertising in the relevant professional journals. Another possibility for the Ministry to consider is a midterm performance review (i.e., at midpoint of the 3 year appointment). This would provide good feedback to DIs.

15.0 Number and Geographical Spread

15.1 The number of DIs has increased markedly in the last few years. In the mid–1960s I was told there were only 2 for the entire country (although there were a number of Official Visitors). On the eve of the 1992 Act coming into force there were 14 DIs (including 1 Deputy DI). At present there are 27 DIs throughout the country including 2 Deputy DIs). Broken down by region, the numbers are as follows: Northland (1), Auckland (5), Waikato (2), Bay of Plenty (2), Gisborne (1), Hawke's Bay (1), Taranaki (1), Manawatu/Wanganui (2), Wellington (3), Nelson/Marlborough (2), Canterbury (2), South Canterbury (1), Otago (2), West Coast (1) and Southland (1).

15.2 Of the 27, 8 are barristers and the others are solicitors in practices ranging in size between 1 to 11 partners. There are 13 women and 14 men. There are no Maori DIs, nor does there appear to be much other ethnic diversity. Given the disproportionate number of Maori receiving mental health services it is highly desirable to encourage applications from suitably qualified Maori lawyers. The Ministry has taken a valuable first step in this direction by consulting the Maori Lawyers' Association. In Australia it has been estimated that between 10–15% of refugees are suffering from mental illness ("Human Rights and Mental Illness" (Human Rights and Equal Opportunities Commission, Canberra, 1993)) and if that figure has any validity in New Zealand this underscores the need for more ethnic diversity in the inspectorate. Advertising DI appointments in the relevant communities might assist.

16.0 Workload and Budget

16.1 There is an expectation that DIs will conduct their duties in addition to their work in a full–time law practice. As the workload has grown so has the proportion of the DIs' practice time given over to DI work. In the larger centres and those with a high concentration of in–patient facilities, where the pressure of work seems to be most acute (notwithstanding additional appointments in recent years), it was reported to me that up to, and in some cases far more than, half a DI's professional time is taken up with this work. There are also some DIs who say that if they followed the requirements of the Act to the letter it would be nearly a full–time job. As they cannot afford that amount of time away from their practices and would not feel comfortable charging for all that time, those DIs admit to cutting some corners. There is tremendous variation in workload (as indicated by monthly billings) across the country and even within areas. A set of figures I saw for the financial year 1994–95 gave the lowest and highest annual payment to individual DIs as $5,331.08 and $185,987.87 respectively. The average figure was $61,778.89 and the median was $46,505.14.

16.2 The approved standard charge out rate for all DI work is $150 an hour for official duties and $75 an hour for travelling time. In my experience this is less than an experienced practitioner in a lucrative practice might command but this has to be balanced by the steady nature of the work, almost certain prompt payment and the somewhat routine nature of some of the tasks. It can also be a stressful and possibly even dangerous job at times.

16.3 The DIs are paid out of non–departmental output class (NDOC) money. In other words, the money does not come out of the Ministry's budget but comes directly from the Crown for this purpose. The expenditure on DIs has risen from $1.2 m. in 1992–93 to an estimated $1.9 m. in 1996–97. The largest expenditure is in Auckland ($491,518), followed by Wellington ($276,518.76), Manawatu/Wanganui ($162,043.42), Waikato ($109,389.58), Otago ($99,702.81) and Canterbury ($98,803.03).

16.4 The increase in workload as indicated by increased expenditure requires explanation. I am told that the number of patients subject to cto has not changed markedly in recent years (although up–to–date figures are not available). If this is true then the explanation must lie elsewhere. There is anecdotal evidence which suggests that, while the number of committals may not have increased, the number of persons under assessment has. I have not been able to pursue this in the time available but I recommend the Ministry endeavour to ascertain the causes of the apparently increasing workload.

16.5 In any system of demand–driven, self–managed workload remunerated by the hour there will always be a suspicion in the minds of some people of work creation. That concern was voiced to me. I cannot say whether the concern is justified or not. All I can say is that the higher billing DIs must have very busy and lucrative practices if DI income makes up only part of their income. The Ministry has taken sensible steps to monitor DIs' costs. The stage has been reached, in my view, when a cap should be put on the overall budget and if need be consideration should be given to capping some individual DIs' billings. There would appear to be power to do this under s. 94(4).

17.0 The Watchdog Role

17.1 The DIs perform several distinct but clearly related functions, which, taken together, constitute the DI as a watchdog of mentally disordered patients' rights. There is little utility in looking back to the roles performed by DIs under earlier legislation. While many of their powers were carried forward without change from earlier legislation, the premises of the 1992 Act are significantly different. The recognition of the extraordinary power to detain mentally ill people against their will finds expression in the 1992 Act in the list of patients' rights (ss. 64–75) and what only can be described as the "juridification" of the assessment and review processes. The involvement of lawyers, judges and legal processes abound, all to the end of ensuring that only those persons who must be detained for assessment and treatment against their will – for their own protection or that of others – are detained. Detention

should be for no longer than necessary and, while detained, proposed patients and patients should continue to enjoy as many civil rights as is compatible with their compulsory treatment. The Act is strict in its requirements and the DIs are embedded in the legal protections conferred for the benefit of the patient. It is not uncommon to see the DIs' role analogised to that of the Ombudsmen.

17.2 These days all forms of regulation must be justified. The watchdog role performed by the DIs is a form of social regulation of the State–funded providers of mental health services to those persons under cto. The role is justified by the extraordinary power, unique to the State, to lawfully deprive mentally ill persons of their liberty in order to administer treatment against their will. No one I spoke to denied the need for some group or agency to ensure that the rights of mentally disordered patients in these circumstances are protected and respected. Some thought the Act as a whole went too far in this direction to the detriment of speedy, effective treatment ("people dying with their rights on"), while others thought the DIs ranged far too widely beyond the legitimate role of ensuring the legal rights of patients are respected. Nevertheless, the justification for some form of regulation is clear and was unchallenged by the people I consulted. That does not answer the question, which several people both within and outside the Ministry have raised with me, whether the DIs should continue to perform this regulatory function.

17.3 That question cannot be addressed until later but I should advert briefly to the argument here as it will crop up also in describing the DIs' functions below. The 1992 Act was a reaction to the well–known defects in the earlier mental health system, which failed to prevent widespread abuse of mentally ill patients. Some say that people in the mental health system remain prisoners of that history, and as long as that continues mental health will never be integrated or mainstreamed into the rest of the health system. Those of this persuasion are attracted to the option of replacing DIs with the consumer advocacy services under the umbrella of the Health and Disability Commissioner. Those and the other health reforms of the 1990s occurred after the 1992 Act, and that is given as another reason for taking a close look at that piece of the regulatory framework comprising DIs. The contract model

underpinning the funder/purchaser/provider split, and the resulting business and competitive imperatives, has also highlighted on occasions the inevitable tension between "getting on with one's business" and regulatory oversight by DIs. In addition, in the background is the ongoing policy work on the regulatory framework being done by the Ministry.

17.4 In discharging this watchdog role, the DIs perform four distinct but related functions: (1) the provision of information and checking of documentation/processes; (2) visitation and inspection; (3) complaint handling and resolution; and (4) conducting inquiries. I note here that the Act authorises the DIs to delegate many of their particular functions to an office–holder called the "Official Visitor" (although I am informed this seldom, if ever, occurred). Official Visitors are lay people (i.e., non–lawyers), appointed by the Minister, who in the past visited mental institutions, inspected the facilities, befriended and assisted the patients, and generally kept their eyes and ears open. For various reasons I need not go into, a decision was made in 1996 not to reappoint any Official Visitors. The consequence is that the entire burden of the above mentioned functions falls on the DIs.

17.5 There is provision for the appointment of Deputy DIs [DDI], and 2 have been appointed. There is presently no flexibility in the duration of DDI appointment (it is for 3 years, the same as DIs) although proposed amendments will permit short term appointments to cover for DI absences. The Act does not specify the role of DDIs but I can see nothing to prevent the Ministry in consultation with DIs drawing up appropriate guidance on delegation of certain tasks. I see some scope for delegation of the more routine tasks to DDIs, who could be more junior lawyers and paid at an appropriately lower rate. This might develop into a useful 'understudy' role, which would ensure continuity and aid in developing a team approach.

18.0 Provision of Information and Checking of Documentation/Processes

18.1 The DI is closely involved in the processes of assessment and review of mentally disordered patients. Without going into detail, the DI is obliged to

the Director. This form of reporting, as an accountability mechanism, is considered below at para. 22.5.

19.5 It has been put to me forcefully that inspection is an old fashioned and inefficient means of regulation that is no longer appropriate. Measuring performance by CHE and NGO providers against contractually specified outcomes can be better monitored in other ways, it was said. I think this underestimates the many valuable functions served by inspection. Inspection as an administrative device or regulatory tool has a very long history, and it is no exaggeration to say the welfare state was built upon its back. See generally David Roberts, *Victorian Origins of the British Welfare State* (Yale University Press, 1960). In the literature on regulation a distinction is usefully drawn between proactive and reactive enforcement. See Bridget Hutter, "An Inspector Calls: The importance of proactive enforcement in the regulatory context" (1986) 26 *British Journal of Criminology* 114. Proactive enforcement involves inspectors going out to the places of treatment on their own initiative, rather than reacting to a complaint or event. Proactivity works best when, for whatever reason, complaints may not be forthcoming. It enables inspectors to see problems or potential problem areas and to ensure they are nipped in the bud and do not accumulate. This may be particularly valuable in the mental health context. Almost everyone I spoke to agreed that most mentally ill people are not likely to complain; they are disempowered, often heavily medicated, and many have been uncomplaining victims most of their lives. Calling someone or an office out of the blue to complain is not realistic for most mentally ill patients. Of course, there is a minority that complain all the time. The DI will have seen each patient twice and the regular visits to the hospital or service reinforces that presence and affirms availability. It is a question of being seen and being known. As a regulatory mechanism inspection seems particularly well suited to mental health given the coercive environment and the uncomplaining nature of many of the patients.

19.6 I note in this regard Principle 22 of the United Nations Assembly Resolution on "The Protection of Persons With Mental Illness and the

Improvement of Mental Health Care" (adopted 17 December 1991), which provides:

> "States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the *inspection of mental health facilities*, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient."[emphasis added]

New Zealand supported this resolution. Such international instruments are increasingly influential on domestic law and policy formation. It appears that in many instances the regular visits take place in conjunction with seeing patients as part of the assessment or review processes or in relation to complaint investigation.

20.0 Complaint Handling and Resolution

20.1 The 1992 Act laid down for the first time a list of patients' rights (ss. 64–74) and required any complaint of denial or breach of those rights to be referred to the DI for investigation (s. 75). The Act is clear that any complaint received by the provider must be passed on to the DI. In other words, any internal complaint mechanisms provided by the provider is displaced. In practice, however, if a complaint comes to the provider it is often handled internally and the DI will await that report before deciding whether to become involved. That seems sensible to me but it flies in the face of the Act. Consideration should be given to amending the Act in order to give the DIs a discretion not to investigate until internal complaint mechanisms have been exhausted. This would be in line with the provisions of the Ombudsmen Act 1975.

20.2 Providers of publicly funded mental health services are required to maintain a fair and speedy consumer complaints service. The funding agreements with the former RHAs specified in some detail the services

required to be purchased or provided: see Ministry of Health, "The Compendium Issue of the Regional Health Authorities 1996/97 Funding Agreements" (1997) pp. 142–3. It appears that all the regions require consumer complaints policies to be in place in purchasing agreements, although some follow more closely the funding agreement language than others: see Ministry of Health, "Contract Monitoring: Review of 1994/95 Contracting" (August, 1995) p. 107.

20.3 It would be useful for the Ministry to collate the consumer complaints service requirements in all the purchase agreements with CHE and NGO providers of mental health services, and to make them available to the DIs in each area. This will not only heighten awareness of the appropriate place of the DIs in the complaint handling structure but might assist in the monitoring of the providers' compliance with that aspect of the purchase agreements.

20.4 When conducting an investigation a DI must speak with the patient and everyone involved. If satisfied the complaint has substance the DI must report the matter and any recommendations to the DAMHS, who is required to "take all steps as may be necessary to rectify the matter"(s. 75(3)). On concluding an investigation the DI must inform the patient or complainant (if not the patient) of her or his "findings"(which, no doubt, would include any recommendations made to the DAMHS). If the patient or other complainant is not satisfied by "the outcome of the complaint" to the DI then the case can be referred to the Review Tribunal for further investigation (s. 75(3)). Apparently the Tribunal in such cases refers the matter back to the DAMHS for reconsideration, which has been described as "a notoriously circular and 'toothless' remedy for an alleged breach which may, at the end of the day, result in no action being taken..." (Warren Brookbanks, "Remedies", work in progress).

20.5 Section 75 is a rather bald provision dealing with investigations into what in some cases will be serious allegations. It does not contain the procedural elaboration or powers to gather information that one would expect in a modern statute. This can be a considerable advantage in that the vast majority of complaints can be dealt with informally and very quickly. In the

small number of cases involving serious complaints or those resistant to quick informal resolution some DIs have felt a little nervous about their legal powers and this is said to be one reason why some complaint investigations of denial or breach of rights have been inquired into by DIs under s. 95 (see below at para. 21.1). For this reason a limited immunity provision is proposed for inclusion in the forthcoming Mental Health (Compulsory Assessment & Treatment) Amendment Bill [hereafter referred to as Amendment Bill]. The interaction between s. 75 complaint handling and s. 95 inquiries is considered further below at para. 21.1.

20.6 The reporting of substantiated complaints of breach of patients' rights by DIs to the DAMHS is problematic in several respects. First, the feedback loop to the patient is nonexistent. The DI is obliged to report her "findings" to the patient or complainant. But the rectification of the matter is in the hands of the DAMHS. There is no formal requirement on the DAMHS to communicate with the patient or complainant as to what (if anything) has been done or of the reasonable steps taken by the DAMHS to rectify the situation. This is the real "outcome" of the complaint (rather than the DI's "findings") and the patient/complainant must know about this before an informed decision can be made to take the matter to the Review Tribunal. Second, the DAMHS appear to be placed in an invidious position. Upon receipt of a substantiated complaint a DAMHS is under a statutory duty to take all necessary steps to rectify the matter. DAMHS are usually senior clinicians employed by the CHEs who are designated DAMHS and exercise a number of powers under the Act (see further Part C of this Report). Sometimes DAMHS will hold a management position like Director of Clinical Services but often does not. Reasonable efforts to rectify breaches of rights will often require management intervention and sometimes expenditure. No doubt DAMHS achieve all that is necessary by persuasion but there is no mechanism by which they can compel managers or staff to do anything to rectify breaches of patients' rights. In short, the complaint system can break down at this point, and there is potential to strain relations between DAMHS, DIs, managers and staff. Third, the reporting line upwards in respect of rectifying substantiated complaints is not clear. In contrast to DIs' visit reports (which go to DAMHS with a copy to the

criticism has to be balanced by the fact that the Act authorises DIs to inquire into "the management of the hospital or other service" (s. 95(1)(b)) and the trite observation that patients' complaints will often have their source in staff, management or funding issues. For example, if an issue arises about denial of the right to treatment in s. 66 due to an insufficiency of acute beds this may lead to funding and allocation issues. There is no clear line demarcating the individuated nature of the complaints system and systemic issues. There is no simple solution in my view. To axe the inquiry function might satisfy some providers, but would likely hamper the DIs in the legitimate exercise of their watchdog role to the detriment of patients and ultimately society. The truth seems to be that good judgement needs to be exercised in deciding whether or not to initiate a formal inquiry and the problem, according to some people, is that that has not always been exhibited. Such formal inquiries can impose potentially large costs on providers and others who feel compelled to defend their reputations and business interests. DIs need to be as accountable as possible consistent with their essential independence from providers. It is a truism that you cannot legislate for common sense (or good judgement), and so I do not see legislative amendment as the answer.

21.3 To properly understand the place of the DIs' power to initiate an inquiry of a more formal nature (once again I draw a distinction, not reflected in the Act, between formal and informal inquiries: see para. 21.1) it has to be put in the context of the other powers of inquiry available in the health sector. I put to one side Royal Commissions and Commissions of Inquiry appointed by Order in Council. (Warwick Brunton in his valuable report referred to at para. 21.1 states that there has been no Royal Commission into Mental Health since 1971 and no Commission of Inquiry specifically into mental health since 1987.)

21.4 There is the power under s. 13(3) of the Hospitals Act 1957 for the Minister to appoint a Committee to inquire into "any matter relating to the management of any institution or any other activity carried on or in connection therewith, or any matter relating to any complaint or dispute that may arise under this Act or any matter arising out of the administration of this Act...".

Where the Minister so directs the Committee shall have all the powers of a Commission under the Commissions of Inquiries Act 1908. Section 47 of the Health and Disability Services Act 1993 authorises the Minister or the DGH to initiate an inquiry into "the purchase or provision of health services or disability services, or both", which (if the Minister directs) has the powers of a Commission under the Commissions of Inquiries Act 1908. The Health and Disability Commissioner can initiate an investigation into any action of any provider whose action is or appears to the Commissioner to be in breach of the Code (s. 35). I note that in the recent case of *Nicholls & Brown v Health and Disability Commissioner* [1997] NZAR 351 (Tipping J.) it was observed that the Commissioner had less extensive powers of investigation than would a Ministerial appointed inquiry under s. 47. Under s. 95 the Director of Mental Health can direct a DI to inquire into any matter referred to in that section and the DI has an independent discretion to do so as well.

21.5 What does the DI initiated inquiry add to this array of inquiry powers? Most obviously it is the only one which is initiated by someone on the ground who can act proactively and in many cases quite informally and speedily to enforce the provisions of the Act and regulations. The powers and immunities provided have supported the handling of difficult complaint investigations under s. 75 but with the hoped for passage of the Amendment Bill those immunities will obviate some of the reliance on s. 95. At that point should the power be repealed or narrowed? I am not convinced that it should. Brunton's report gives no cause for concern that the power has been used irresponsibly in the past. It appears to function as a valuable addition to the rights-based jurisdiction in Part VI, covering other breaches of the Act, regulations made under the Act and any breach of duty by officers or employees (s. 95(1)(a)) and any other matters respecting patients (s. 95(1)(b)). If the office of Director disappears and the DIs' watchdog role is entirely independent of the Ministry (either in a stand alone Mental Health Ombudsmen-type office or as a special inspectorate under the umbrella of the Health and Disability Commissioner) then it is even more necessary that the DIs retain a broader inquiry function.

21.6 The aspect of the inquiry power which most concerns CHEs and other providers is the explicit reference to "[s]uch other matters as the [DI] ... thinks fit to be inquired into respecting ... the management of the hospital or other service". Should it be excised? In the original *DI Report* I said there was something to be said each way on this issue but, on balance, I thought there was more danger of hampering the DIs' legitimate exercise of their watchdog role by excising it than there is to the providers' by leaving it in. I referred to the impossibility in some instances of cleaving patient issues from management issues. In those instances the thrust of the Act is to give priority to patients' rights and protection. Removal of the inquiry power could be seen as a knee–jerk reaction to one or two highly publicised recent DI inquiries, which for whatever reason have been hard (and expensively) fought. The original *DI Report* went on to say that it should be remembered too that excision would deny the Director the power to direct a DI to undertake such an inquiry, which is an equally useful power to have in the regulatory arsenal. The recommended abolition of the office of Director would extinguish that power. If it was thought necessary to retain such a power in the hands of the Ministry, in addition to those already possessed under the Hospitals Act and the Health and Disability Services Act (see para. 21.4 above), then specific legislative provision would need to be made.

22.0 The Accountability of District Inspectors

22.1 As noted above, DIs are appointed by the Minister to perform important watchdog functions under the Act and are paid out of the public purse. It is axiomatic that they should appropriately account for their activities and be as accountable as is consistent with their necessary independence from providers. At present DIs provide a monthly report to the Director and attend two meetings a year convened by the Ministry, as well as having highly variable informal contact with the Director and others in the MHS of the Ministry. I make some recommendations below to improve accountability but first want to discuss the tension between independence and accountability.

22.2 DIs place great stress on their independence from the providers of mental health services, which they say eases communication with patients as

they are not seen as "part of the system". Being practising lawyers reinforces that independence. Some DIs have argued that the fact the Ministry pays them compromises their independence, and they hark back to the one instance some years ago in which payment was refused in controversial circumstances. In the *DI Report* I disagreed with the view that DIs need to be or should be so insulated from the Ministry. Indeed it is that attitude, I said, which had reduced rather than fostered appropriate accountability. The Report went on to say that DIs must come to terms with the fact that they are part of a national inspectorate performing a regulatory/oversight role within the regulatory responsibilities of the Ministry. They should not view themselves as "lone rangers" but rather as members of a team of professionals with responsibility both downwards (to the patients) and upwards (to the Director) for the discharge of their duties. At other times and in other places similar functions have been performed by full–time appropriately qualified public servants employed by a government Department or Ministry, and that remains an option here. It may be one forced on the Ministry if the workload of DIs increases to the point where it is more full–time than part–time or if the expenditure continues to increase. At the present time I would recommend continuing with the present structure subject to the suggested recommendations actually improving accountability and information flows. I recommend also that within a year and well before the next round of (re)appointments is embarked upon in 1999 the matters canvassed in this report be looked at again.

22.3 The focus in the *DI Report* was on enhancing accountability within the existing Ministry structure. Since it was written developments are taking place which open up issues for consideration which were not on the table a few months ago. For the sake of completeness, however, I will reiterate here what I said in the original Report; some of it will be of limited relevance in the event the DIs' jurisdiction becomes independent of the Ministry. It follows from Part A of this Report that the references to the Director in the next few paragraphs should be read as referring to the head of the district inspectorate or a Mental Health Ombudsmen's office.

22.4 The role of the DI is evolving. The office of DI was carried over from the 1969 to the 1992 Act and in the process it was given significant new and

more onerous functions. It has been necessary also for DIs to come to terms with the impact of the subsequent health reforms on the mental health sector in general and on their role in particular. I do not believe it is in the interests either of patients or the public to radically change or abolish the office of DI. The justifiable concerns expressed to me can and should be met in other ways.

22.5 There should be proper line reporting to the Director in all aspects of the DIs' duties. The reporting should be timely and on standard forms specifically developed for this purpose. This will provide a transparent account of how DIs discharge their responsibilities on a monthly basis, as well as facilitating feedback to the DIs as a group on a regular basis thereby improving communication both ways. A regular newsletter from the Director to the DIs drawing attention to trends or points of interest in the reports and other developments of note would be a useful initiative. Similar communication with the DAMHS, providers and patient groups should be considered also.

22.6 The reporting lines laid down in the Act in relation to the four functions discussed above are as follows. In relation to contact with patients during the assessment and review processes there is no formal requirement to report to the Ministry. (Technically speaking, because this contact requires "visits" to patients in hospitals or services it might be argued that such "visits" trigger the reporting obligation in s. 98 but this is neither the way DIs understand the Act nor is the reasoning compelling.) In practice the DIs render a monthly bill and itemise their time commitment but this is an extraordinarily variable and haphazard way to monitor the number and frequency with which people are seen or how the paper work is handled. In relation to the monthly compulsory visits to hospitals and services s. 98(1) requires the DI to submit a report to the DAMHS within 14 days of every visit, and the DAMHS must send that report on to the Director within 14 days (s. 98(2)). This is the legal basis of the DIs' practice of submitting monthly reports to the DAMHS and the Director. This report is not in practice restricted to reporting on visits and can cover the range of DIs' work. In relation to substantiated complaints the inadequate reporting lines have been discussed in detail above at para. 20.6. To recap, the DI

reports to the DAMHS who reports formally to no one on the ultimate outcome of the complaint. In relation to inquiries under s. 95 the DI is obliged to furnish a "full report" to the Director as soon as practicable.

22.7 The present reports are so varied in style, content and coverage as to be useless as a monitoring device or information gathering exercise. In some cases the report reads more like an itemised bill. This monthly report is the principal reporting and accountability mechanism and must be standardised to provide timely and useful information. The account or bill for hours worked should be in a separate attachment and indicate the time spent rather than billable units.

22.8 There is a clear need to clarify the reporting line to the Director in relation to all the functions. Preferably this should be done by legislative amendment. I recommend that the Ministry develop a standard monthly report form to be completed by DIs within 7 days of month's end in terms of workload, number and frequency of patients and visits, number and seriousness of complaints, invocation of inquiry powers and any matters of concern. Presented in this way the information should be more useful and would allow the Director to discern trends and to follow up on matters of concern. It would also make possible the preparation of a regular newsletter to DIs (and possibly others) identifying matters of policy or practice of interest or areas of concern. This form of two–way communication, which occurs now in a less formal and systematic way, is important in fostering a sense of collective endeavour (and in some respects, responsibility) and professionalism amongst the DIs. This may be especially needed with a group of lawyers, who by training and habit tend to work on their own and may be suspicious of 'bureaucracy'.

22.9 One consequence of what I have called the "lone ranger" view of the role of DI is that DIs collectively seem to feel no responsibility for the budget or how their individual workload fits with regional/national norms. The non–identifying information in para. 16.1 shows there are extreme fluctuations in DI income. There must be better systems put in place to more effectively monitor this. This is necessary not least to protect DIs from the suspicion (prevalent in

some quarters) that in some cases the amount of DI work performed fills the available hours. I recommend that the Ministry monitor billings against the detailed reporting form (recommended above) for a reasonable period. The overall budget should be capped at the 1996–97 level as a first step.

23.0 Breadth of District Inspector's Jurisdiction

23.1 I have heard generalised complaints about DIs along the following lines: the breadth of their jurisdiction allows each DI considerable discretion to discharge their duties according to their own understanding of their role and in their own way. It seems to be the case that some DIs are more active in relation to some or all of their duties than others; perhaps some have more time to commit. Some do seem to conceive of their role more expansively than others. I have considered whether this variability can be successfully addressed by amendment and have concluded that it cannot. The best approach is to better monitor performance and to educate DIs as to the limits of the role. Some DIs have become resource persons to the mental health community, irrespective sometimes of whether the person concerned is under the Act. As worthy as that work is, it is not strictly speaking what DIs are paid to do and if DIs cannot bring themselves to turn people away they should not charge for that time. The necessary detachment required of DIs might well be compromised in the eyes of some by DIs taking on of that sort of role on a regular basis. Once again it comes down to good judgement.

24.0 Complaints and DAMHS

24.1 The recommendation in para. 22.5 that DIs report directly to the Director in relation to all their functions, needs modifying in the case of substantiated complaints. There needs to be statutory amendment requiring the DI to direct the substantiated report to the provider (with copies to the Ministry and the THA) and for the provider to be under a duty to respond in a timely fashion to the patient and complainant (if not the patient), the DI, the Ministry and the THA as to how the substantiated complaint has been resolved. This

straightens out the defects in the present system. I can see sense in the DAMHS continuing to receive a copy of the DI's monthly report. There may be some parts of that report which it would be unnecessary for the DAMHS to see (e.g. the attached bill). Consideration should be given to this when compiling the standard form recommended in para. 22.8.

24.2 More generally, in theory there is potential role conflict with the DAMHS employed by the CHE but exercising statutory functions in relation to both that CHE and NGO providers. At the present time the CHEs seem to be subsidising the performance of Ministry regulatory functions by their DAMHS/employees. The subsidisation point can be met by specifically earmarked THA purchasing of this service but that will not meet the role conflict point if DAMHS remain in CHEs. This issue is taken up in Part C of this Report.

25.0 The Role of the Minister

25.1 I have said little so far about the role of the Minister in relation to DIs. The Minister appoints the DIs and can call for briefings on their activities generally or in particular cases. The line of reporting recommended above at para. 22.5 is to the Director and upwards from there to the DGH and the Minister. The Ministry's primary concern is that the DIs perform the various regulatory functions in a competent, efficient and effective manner. A perceived difficulty for the present Minister is that he holds the CHE portfolio as well, and wearing that ministerial hat may receive a somewhat different view of the utility or behaviour of DIs. As long as the (Ministry's) regulatory role is clear and justifiable – as I believe it is – *and* the DIs confine themselves to that role, I do not see any conflict between the Minister's role as head of the regulating agency and his other ministerial role as shareholder (i.e., trustee/agent for the owners/principal, i.e. the public) of the CHE providers. Nevertheless, moving the DIs out of the Ministry altogether would prevent any perceived conflict.

26.0 Conclusion and Modifying Remarks

26.1 The regulatory role of the Ministry was justified above at para. 17.2 and it appears, from my limited consultation, to be accepted across the sector. There is slightly more disagreement over whether the DIs as presently constituted should perform that regulatory role. The overall impression I am left with, however, is of DIs performing a valuable checking, complaint handling and proactive role in a difficult area, discharging their responsibilities competently, diligently and even enthusiastically. There are legitimate concerns about accountability, cost and differences in role perception, which I have attempted to address in a way that recognises that the office is worthwhile and evolving with the sector itself. Ensuring that DIs confine themselves to their watchdog role and perform it in a cost effective manner are the immediate challenges ahead. Failure to meet those challenges within a reasonable time frame (I have suggested by mid–1998) should prompt reconsideration of the delivery mechanism.

26.2 In the months since the above paragraphs were written and in the course of discussions in relation to the DAMHS and the Director Reports I have become even more convinced of the worth of the DIs. I continue to subscribe to the importance of the accountability of DIs. In the event that the Directorship is abolished, accountability of the DIs can be assured by following as far as appropriate those requirements pertaining to the Ombudsmen or the Commissioner, depending upon whether the DIs' jurisdiction is placed in a stand alone Mental Health Ombudsmen office or in a separate inspectorate under the administrative wing of the Health and Disability Commissioner.

PART C: The Role and Accountability of Directors of Area Mental Health Services

27.0 Introduction

27.1 As indicated in para. 1.3 above, this Part comprises my earlier draft *DAMHS Report* modified to reflect the discussion and recommendations made in Part A in relation to the Director and also takes account of views expressed within the Ministry and in a late detailed submission by HealthCare Otago. A list of the persons consulted appears in Appendix 4.

28.0 The Qualifications and Appointment of DAMHS

28.1 Originally under the 1992 Act a DAMHS was appointed by the Board of each Health Area (s. 92 & definition of "Director of Area Mental Health Services" in s. 2). After the disbandment of the Area Health Boards and their replacement by the CHEs, the Act was amended so that DAMHS are now designated by the DGH. The designation is made by a notice published in the *New Zealand Gazette*.

28.2 The practice is that a DAMHS is nominated by the employing CHE and the Director–General, after seeking input from the Director of Mental Health, makes the designation. The Act does not specify any formal qualifications or criteria for appointment. In practice the majority of DAMHS are psychiatrists, and the others are experienced clinicians or nurses. The draft Ministry "*Guidelines*" declare a preference for DAMHS to be psychiatrists. I understand that there are historical and other good reasons for the departure from that norm in parts of the country, and it has been said that it would be too confining to require psychiatric training as a qualification.

28.3 There is no term of appointment specified and no explicit conferral in the Act of a power to suspend or remove DAMHS. Once appointed DAMHS are in place indefinitely unless and until they forsake the position, resign from

their employment or are replaced at the initiative of the CHE (or, conceivably, the DGH). This is important in the context of accountability as scrutiny of performance at times of periodic reappointment is a primary accountability mechanism. Its absence here puts even greater store on the other available accountability mechanisms. I do not see how any limited term appointment could be made to work in the present structure. Instead, I recommend that the Ministry initiate discussions with the CHEs and the Association of DAMHS with a view to adopting a policy of reviewing, as an administrative matter, the performance of DAMHS every three years. In particular the feasibility of peer review should be explored.

28.4 It should be noted that under s. 25(h) of the Acts Interpretation Act 1924 the DGH has the power to remove, suspend or replace DAMHS. It would be desirable, however, to have all the relevant powers in the 1992 Act and accordingly I recommend that s. 92 be amended to include the power to remove the designation at the discretion of the DGH.

28.5 There is no power on the part of the DAMHS to delegate their powers to others. It was pointed out to me that this could cause some difficulty if the present informal delegations to colleagues during absences were challenged in, or not recognised by, the courts. I note that a sensible proposal to deal with that problem is to be included in the Amendment Bill, and I support that initiative.

29.0 Territorial Jurisdiction

29.1 Until recently DAMHS were appointed to areas which represented the old Area Health Board territories, which is a throw back to the pre–CHE days when the Act first came into force. Those area boundaries did not necessarily conform with the CHE or former RHA boundaries. In the last few months, I understand, the areas have been redrawn to conform to CHE boundaries. I understand also that the wording of s. 92 is causing difficulty in that it requires a gazetted definition of each area and that only *one* DAMHS be appointed to that area. I have not been apprised of the details but there seems to be a need

to be able to define areas with some flexibility and to change them easily as circumstances require. The Legal Section of the Ministry should be instructed to prepare such an amending formula for inclusion in the Amendment Bill.

29.2 It is time for the Ministry, after appropriate consultation, to review the number and distribution of DAMHS around the country. Some DAMHS are covering several CHE areas already. There may well be some benefit in amalgamating some other areas under one DAMHS. Indeed, some form of regionalisation may be possible. I am not convinced that a national view has been taken of the distribution of DAMHS and think there is benefit in doing that. Objections to such rationalisation on the ground of a competing CHE's employee having 'jurisdiction' over other CHEs and NGO providers in an area must now be tempered by the Coalition Agreement on Health. Objection on the ground that the CHE housing the DAMHS is providing a regulatory service to other providers and that the amount of that cross–subsidy needs to be paid by the THA or the other providers is valid. This concern should be addressed as part of the discussions recommended below at para, 35.1–35.2.

30.0 Workload

30.1 It has not been possible for me to get a clear picture of the workload of DAMHS around the country. Some of those consulted said that their functions as DAMHS and their work as clinical leaders merged together making an accurate assessment of time spent on DAMHS work difficult. Other DAMHS have a specified amount of time for that work in their employment contract. Of that group the highest figure I heard of was halftime (i.e., a 0.5 appointment) and the lowest was a fifth (i.e., a 0.2 appointment). There is clearly some value in the specification of the portion of a DAMHS/employee's time to be spent on DAMHS work. This may become important for funding purposes but it is necessary also to enable the Ministry to monitor effectively the discharge of those functions on a national scale and to detect regional variations which may require explanation. It is not clear to what extent the Ministry is discharging that role at present.

30.2 This seems the most appropriate place in to address the issue of the attractiveness of the position. Why do people become DAMHS and why do they continue in the position? It should be noted in this regard that some of the DAMHS have been in the position from the beginning of the new Act or nearly so. It is considered to be a demanding job at times and can be frustrating if the DAMHS is unable (for whatever reason) to influence the actions of the CHE and the THA. Most DAMHS liked the national outreach of the office and the opportunity to put systems in place to ensure quality care. I did not detect a high level of dissatisfaction or burn out.

31.0 Conception of DAMHS Role

31.1 There appears to be considerable disagreement as to the role of DAMHS under the Act. There are 25 references to the office in the Act, and there is considerable room for differing inferences to be drawn as to the legitimate functions to be performed. The Act is not sufficiently explicit to erase uncertainty as to the role of DAMHS. Moreover, beyond the roles assigned by the Act, there are issues as to whether the role of DAMHS continues to be justified in light of the reforms introduced in the health sector since 1993. These two issues, related but separate, will be explored below; but first must be listed the DAMHS statutory responsibilities under the Act as it presently stands.

31.2 The following list of statutory responsibilities is taken from the draft Ministry paper entitled "Appointment and Role of Director Area Mental Health Services" (dated 30 September 1996) [hereafter referred to as *Guidelines*] prepared by Dr Wayne Miles (DAMHS, Waitemata Health) and revised jointly by the Association of DAMHS and the Ministry:

1. Ensuring that each patient is assigned a responsible clinician, and approving suitable clinicians as responsible clinicians (s. 7);
2. Receipt of application for assessment (ss. 8, 45);
3. Arrangement of assessment interview (s. 9);

4. Receipt of the certificate of preliminary assessment, etc (s. 10);
5. Receipt of certificate of further assessment, etc (s. 12);
6. Receipt of the certificate of final assessment, etc (s. 14);
7. Removal of special patients back to penal institutions (s. 47);
8. Transfer of special patients (s. 49);
9. Leave of special patients (s. 50);
10. Direction of temporary return of special patients to hospital (s. 51);
11. Retaking special patients who escape or are absent without leave (s. 53);
12. Referral of patients with special difficulties to the Director (s. 54);
13. Receipt of complaint of breach of patients' rights (s. 75);
14. Receipt of clinical reviews of patients subject to compulsory treatment orders (s. 76);
15. Receipt of Tribunal reviews of patients (s. 79);
16. Designation and authorisation of Duly Authorised Officers; including responsibility for their training and competence (s. 93);
17. Issuing document of authority to DAO and directing duties of DAOs (s. 93);
18. Maintaining lists of telephone numbers for assistance or information (s. 93);
19. Receipt of DI reports (s. 98);
20. Assessment of persons apprehended by the Police (s. 109);
21. Assessment of persons urgently assessed by a medical practitioner (s. 110);
22. Applying for a warrant to apprehend a patient or proposed patient (s. 112);
23. Non–obstruction of DI inspection (s. 117);
24. Approval of vetting of incoming mail (s. 123); and
25. Transfer of patients (s. 127).

31.3 The DAMHS discern from this long list of statutory responsibilities that a DAMHS is intended to have a number of "clinical management responsibilities", including:

1. Ensuring there is psychiatric evaluation and reviewing that evaluation and subsequent decisions regarding need for compulsory treatment and discharge;
2. Monitoring, through receipt of documentation, the quality of clinical decision-making and its recording, and the rectification of complaints;
3. Considerable direction over DAOs and, although less explicit, "a line of accountability" between responsible clinician and DAMHS;
4. Based on the responsibility to rectify breaches of rights, the DAMHS "must be expected to have influence on the delivery of care beyond the purely medical" (*Guidelines*, p. 3).

Furthermore, in the *Guidelines* it was said to be "imperative", in order to discharge those clinical management responsibilities, that the DAMHS have certain "authorities". In addition, in order to "obtain and retain" those authorities the DAMHS were said to need "relationships of defined influence" with the purchaser and provider, and, to assist in their accountability, with the Ministry through the Director (p. 4).

31.4 This conception of the role has the DAMHS as exemplars of best clinical practice, ensuring that patients receive the best treatment possible within the letter and the spirit of the Act. On this view the DIs and DAMHS can usefully be seen as occupying different sides of the same coin. Both are there to protect the rights and interests of patients, who have been lawfully deprived of their liberty by the State in order that treatment can be administered against their will. Whereas the DI is the external legal watchdog of patients' rights under the Act, the DAMHS is the internal clinical watchdog of patients' rights and treatment. In essence, the justification for the regulatory functions of both DIs and DAMHS is the same.

31.5 This conception is challenged strongly by HealthCare Otago. The flavour of its extensive submission is captured in the following summary:

> "DAMHS' current statutory role is administrative, clinical and supervisory. However it is unnecessary to have the separate layer of bureaucracy created by DAMHS in order to perform these tasks. CHE

staff are trained and capable to do them and there would be advantages, both in efficiency and effectiveness, if these tasks were integrated into everyday CHE operations.

DAMHS want a more managerial role but this would exceed statutory authorisations and would overlap with the work and expertise of CHE CEOs and General Managers of Mental Health, resulting in inefficient and ineffective management.

The only justification for DAMHS could be an independent monitoring role. Such a role is not statutorily authorised. Moreover to the extent that the DAMHS' roles de facto serve a monitoring function, they are unnecessary. The ... [1992] Act ... provides for comprehensive monitoring and safeguards through information and rights granted to the patient and his/her caregivers etc, through the District Inspectors ..., via Review Tribunals, review by the Courts and ethical obligations of medical staff. Furthermore, CHEs have statutory obligations under the Health and Disability Services Act ... that render daily monitoring unnecessary. Still further, ... the THA ... provides oversight of CHEs as purchasers of their services. CHEs are contractually bound by their purchasing agreements. In addition, the Mental Health Commissioner, the Health and Disability Commissioner, and Hospital Inspectors represent independent review mechanisms. The New Zealand Bill of Rights Act 1990 also offers a statutory basis for judicial redress regarding breaches of patient rights.

There is a need for strong and comprehensive watchdog roles and functions within the mental health system and particularly with regard to compulsory treatment. However, the current web of interrelated and ill–defined roles is obstructive to the need for, and intent of, the roles and functions. DAMHS represent one of the least–value–added monitoring roles, and frankly are not needed due to a range of other safeguards. They should be abolished, leaving CHEs responsible for administrative, clinical and supervisory tasks. Independent monitoring should be effected by the various mechanisms provided for under the MH Act as well as the range of other watchdog entities and roles."

31.6 In relation to what the Act presently requires of DAMHS there is possibly more common ground between the DAMHS and the CHE than might appear. The latter acknowledges the existing administrative, clinical and supervisory roles of DAMHS but rejects as unauthorised any management or monitoring role (while acknowledging that some de facto monitoring goes on). Nonetheless, the underlying conception by the CHE of the DAMHS role is that of a paper collector and repository; unnecessarily managing a paper trail.

31.7 Although the Act is not as explicit as it might have been, there is a certain implausibility to the claim that DAMHS were and are totally unnecessary. The many statutory responsibilities heaped on DAMHS indicate that the designated person is responsible for the operation of the Act's processes on the ground at the local level. It does not seem unreasonable for the Legislature, which provided extensively in the 1992 Act for legal processes and protections, to provide for the designation of a qualified person to administer and oversee the coercive process as "agent" on the ground. There is also the great advantages of certainty and consistency across the country that leaving such arrangements to each CHE would threaten. Furthermore, nothing has happened in the legal environment since 1992 in relation to the administrative, clinical and supervisory roles of DAMHS that has rendered those roles otiose or which would make one suspect that the Legislature made a mistake in providing for DAMHS in the 1992 Act. There are difficulties, in my view, in the stringencies and legalism of the 1992 Act, but to chip away at the protective fabric surrounding the rights without revisiting the rights and processes themselves is ad hocery. On the basis of my consultations there does not appear to be much support for the abolitionist stance of HealthCare Otago.

31.8 There is, however, lurking beneath the surface a distinction between liberty/autonomy and quality of treatment. Everyone seems to accept that deprivation of liberty/autonomy justifies regulatory protections, and that this sets mental health apart to some degree at least from the rest of the health sector (see further on this paras 37.1–37.5). But, it is said, in every other respect once the patient is under a compulsory treatment order why should the monitoring of the quality of the care be any different to that pertaining to patients suffering from illness, disease or injury unrelated to mental disorder? This question seems to me to lie behind much of the resistance to the claimed managerial and monitoring roles by DAMHS. There are two partial responses. One is the exceptional duty to treat patients under s. 66 of the 1992 Act (but one must acknowledge the debate as to whether this provision applies only to medical treatment not related to mental disorder). The second, and the more powerful, is that there is the continuing serious risk to the safety of the patient or to members of the public posed by the patient if the treatment is not

provided or is inappropriate. The reason for detention/coercion (in other words, the regulatory justification) merges with the monitoring of quality and sometimes managerial issues in ways that do not occur (at least as continually) in other areas of 'voluntary' medicine practised on patients who are not mentally disordered.

31.9 It is evident from the quoted extracts from the DAMHS–inspired *Guidelines* and the CHE's submission that there is a good deal of self interest on both sides of this debate. I do not have any data to resolve the issue of the utility of DAMHS or the degree to which they add value to the sector or to the administration of the Act. There is a good deal of assertion on both sides. If the solitary cry for abolition of the DAMHS is to be heeded, however, there needs to be concrete evidence and a well developed case made out as to how the administrative, supervisory and other roles, presently performed by DAMHS, would be performed by CHE and NGO providers throughout the country. To avoid ad hocery that review should be part of a larger one into the operation of the 1992 Act. I am not persuaded that events or developments since 1992 have rendered what the Legislature provided for in the Act in relation to DAMHS as either unnecessary or mistaken. Indeed, it seems to me that there may be an enhanced role in the future for DAMHS in providing information to the reconfigured Ministry and the THA. From what I have learnt in this brief review of DAMHS I am not persuaded that they should be abolished. Indeed, apart from HealthCare Otago, the feedback on the operation of the DAMHS was positive and encouraging. The only grumbles relate to resourcing, which is dealt with at para. 35.1 below.

32.0 DAMHS Place in CHE Structure

32.1 At first sight the DAMHS appear to occupy a curious, even an anomalous, position. A DAMHS is an employee of a CHE, who, for part of the time (often unspecified), wears a 'regulatory' hat, exercising various statutory functions as a designated officer. In this latter capacity the DAMHS has authority over other CHE employees (mainly clinicians but not limited to them) and potentially may find fault with the CHE's provision of service, as

well as that provided by any NGO providers. It would seem to be a role fraught with actual or potential conflicts of interest. Again on first impression, the conflicts would appear to be exacerbated the more closely the DAMHS is involved in managing the clinical team (as Director or team leader). Furthermore, there is the possibility that NGO providers or other CHEs whose areas overlap with the CHE in which the DAMHS resides may look askance at the employee of a 'competitor' concerning her or himself in their activities.

32.2 The purist position would be for DAMHS to be independent of CHEs altogether and to be contracted directly (by the Ministry or the THA) to provide those services. As attractive as that separation is in theory I have become convinced that it would not work for the following reasons. First, the CHEs employ almost all the clinicians who have the day–to–day practical experience and expertise required of DAMHS. Appointment of such a person independent of a CHE would not be a practical possibility in many parts of the country. Even where it might be possible there is the risk of such a person losing touch with the realities of clinical practice. Second, there was a strongly held view amongst the people I consulted that the DAMHS is most effective in discharging her or his statutory responsibilities within the CHE setting. Lastly, and relatedly, there was no support whatsoever from those I consulted to take the DAMHS out of the CHEs. (HealthCare Otago, which strenuously objected to the continuation of the office of DAMHS, did not suggest separation from the CHE as a fall–back position. Indeed, that CHE recently appointed their DAMHS as clinical team leader.)

32.3 Within the CHE it appears, as a general rule, that the most effective position a DAMHS can hold is that of Director of clinical services or team leader. This is said to give the DAMHS/Director "clout" with management and clinicians. In this way the DAMHS voice (and thus the regulatory imperatives) are heard at the management table and can be reflected in planning, budget setting and service delivery. Initially I had to suspend my disbelief that the imbrication of DAMHS functions and clinical leadership within a CHE would not heighten role conflict. However, questioning of former and present DAMHS and CHE managers has persuaded me that,

contrary to my first impression, the combination of DAMHS and clinical leadership does enhance the discharge of the statutory functions as long as two conditions are met: (1) the person is suitably equipped for both roles; and (2) there is sufficient external accountability for discharge of the DAMHS functions. There will inevitably be some role ambiguity, not to say conflict, but that can be managed in part by appointing the best equipped people as DAMHS, in part by educating others as to the distinctive regulatory functions the DAMHS discharge and in part by strengthening and making more visible external accountability mechanisms.

33.0 Relationship with the THA

33.1 There seems to have been a difficult relationship in some parts of the country between DAMHS and the former RHAs. Difficult in the sense that some of the former RHAs have been said to have virtually ignored input from the DAMHS and not sought advice from DAMHS in contracting for the provision of mental health services. The DAMHS as a group have sought a "relationship of defined influence" with the THA (see *Guidelines*, p. 4). I would encourage the development of such a relationship, and it is pleasing to see that relations have improved recently. It makes sense for the expertise of the DAMHS to be utilised by the THA. This is related to the question of explicit provision as to DAMHS in the provider agreements, which is discussed below at paras 35.1–35.2.

34.0 Accountability of DAMHS

34.1 One concern with DAMHS is that there is no clear link between them and the Ministry, nor is there ongoing accountability to, or monitoring by, the Ministry. Although DAMHS are appointed by the DGH the formal connection with the Ministry ends there. This is not to deny that there is considerable informal contact with the Ministry. Those DAMHS consulted spoke highly of the helpfulness of the Ministry in providing advice and support when contacted. The fact remains, however, that there is no formal reporting

mechanism back to the Ministry. I put to many of the people I consulted a worst case (and hopefully fictitious) scenario where a DAMHS was not doing a good job but thereby was unlikely to upset the CHE or clinicians, and asked how would that person be held to account for his or her non– or misperformance? The answer that likely, sooner or later, the Ministry would somehow get wind of the situation and initiate an informal resolution of the problem was not reassuring or adequate.

34.2 Fashioning appropriate and effective accountability mechanisms to the DAMHS situation is not easy. One could take a leaf out of the DIs' accountability regime; namely, require the DAMHS to report periodically (possibly every three months) on the discharge of their statutory functions. This would also provide an opportunity for comment on matters of interest or concern. The Ministry would receive more standardised information and, in some cases, maintain more regular contact. This could feed into agenda–setting and discussion at the regular (presently quarterly) DAMHS meetings with the Ministry. This suggestion was not greeted with enthusiasm by all those I consulted. I share their disdain of form filling for appearances sake, but I am not convinced that a report of the kind envisaged would fall into that category. The lack of a formal reporting line to the (appointing) Ministry is undesirable under the existing arrangements within the Ministry. After coming to this conclusion I was gratified to discover that the Ministry had already set in train an amendment to this effect in the Amendment Bill. In my original *DAMHS Report* I recommended that the Ministry, in consultation with the Association of DAMHS, develop a standardised reporting form for this purpose. The imminent moves on the part of the Ministry to divest itself of operational policy suggests to me that the reporting line should be to the THA with copies of the report to go to the Chief Psychiatric Advisor in the Ministry and to the DIs' Office (either as a stand alone Mental Health Ombudsmen office or an inspectorate run from the Health and Disability Commissioner's office).

35.0 Funding

35.1 There is a good deal of interest in the issue of the cost of discharging the DAMHS statutory functions. Some of the CHEs say that they have absorbed the not inconsiderable costs of this regulatory oversight function mandated by the Act for too long, without explicit provision in the provider agreements and without full payment to cover those costs. They draw an analogy with the Medical Officers of Health whose services, in effect, are contracted for by the THA. A number of suggestions were made to me regarding the desirability of making the provision of DAMHS services a part of the provider agreements. It was thought to be useful to specify the amount of time the DAMHS was expected to act as DAMHS. At present the amount of time devoted to this work varies considerably (see above at para. 30.1).

35.2 At present DAMHS are appointed by the Ministry and paid from funds provided by the Crown through the THA. There is no objection in principle to that. Indeed it seems preferable on practical grounds to the alternative of the money being channelled through the Ministry either to the individual DAMHS or the CHE. The fact remains that DAMHS need to have better defined relationships with the THA. I have a concern, however, that desirable attempts to gain greater recognition and specificity of DAMHS work in the provider agreements could degenerate into a funding impasse; with the CHEs trying to claw back the cost of cross-subsidising these regulatory functions (as some see it) and the THA declaring that it has no additional funds from the Crown to pay any more for such services. That would not make the DAMHS any more effective in protecting the welfare of patients, which is their *raison d'etre.* This is not an issue I can run to ground in this short review but it is of central importance. Some CHEs are unhappy with the present situation and I am told will be pursuing the matter with the THA. I recommend that the Ministry take an active role in initiating discussions between the THA, CHEs and the Association of DAMHS on this important issue. This seems an auspicious time to do so. The past relationship between RHAs and DAMHS has not been happy (see above at para. 31.1). The advent of the THA provides an opportunity to address these issues in a constructive way at the national level.

36.0 Conclusion

36.1 This Part of the Report affirms the regulatory role the DAMHS perform under the Act. While their employment relationship with CHEs appears anomalous, it works better than any alternative arrangement. The regulatory functions are inextricably linked to clinical practice and cannot be separated without impairing both. That necessitates, however, enhanced accountability for the discharge of the DAMHS statutory functions and must entail a defined reporting line to, and relationship with, the THA. There are some issues regarding DAMHS that require attention but they should be discussed constructively. There is an opportunity here for the Ministry to bring together the interested groups to talk through issues of territorial jurisdiction, cost sharing, funding, periodic peer review of DAMHS and the other issues raised in this Part of this Report. To leave these issues to be addressed (if at all) on a piecemeal and regional basis would be unsatisfactory.

36.2 The imminent shift of operational policy from the Ministry to the THA and the recommended abolition of the Directorship has shifted significantly the ground upon which the original *DAMHS Report* was constructed. The concern about the missing reporting link from DAMHS to the Ministry has been overtaken by events. The issue of DAMHS accountability is still very much alive, however. In the light of the recommended abolition of the Directorship, the logical reporting and accountability line is to the THA.

PART D: Conclusion

37.0 Concluding Remarks

37.1 In the course of consulting fairly widely over the last few months in relation to the three Reports brought together here, I have gathered a clear impression of the broad differences of opinion (both within the Ministry and outside) over the place of mental health in the health sector and the State's regulatory role in this sphere. It may be helpful if, by way of conclusion, I outline them briefly and put my conclusions in that frame.

37.2 Everyone appears to concur – or, at least, no one is prepared to openly disavow – that what makes mental health unique in the health sector is the fact that the State forces treatment on persons against their will, and sometimes has to incarcerate them to do so. That justifies the State's role in ensuring that this is done in accordance with law and that the patient's legal rights are respected and clinical needs met. Some, however, obviously think this difference is overplayed and yearn for the day when mental health is homogenised with the rest of the health sector. Separate treatment of mental health is viewed as 'privileging' that area, setting it apart and somehow cocooning it from the reforms elsewhere in the health sector. Of course, the claim that mental health is somehow 'privileged' rings hollow in the ears of others who point to historic and continuing systematic marginalisation, etc. That group tend to the view that the deprivation of autonomy and liberty by the State will always – and should always – set mental health apart from the rest of the sector.

37.3 This division of opinion is reflected also in responses to the role of social regulation as exemplified by the Director, DIs and DAMHS. For those sceptical of the continuing differentiation of mental health from the rest of health, these forms of social regulation are often viewed as a "crutch" on which providers lean, preventing them from standing on their own two feet and taking responsibility for their own business activity and service provision. Their

impulse is to kick the crutch away in the belief, expectation or hope that the providers will walk and then run without stumbling or falling.

37.4 Those in the opposing camp see this form of regulation as a necessary support preventing or at least minimising the risk of stumbles and falls. They point also to the uneven quality and quantity of mental health services across the country as underlining the need for nationally constructed and maintained supports, at least until the standards of service provision improve across the board. To remove the supports prematurely runs the unacceptable risk of services stumbling with the well appreciated human, societal and political repercussions.

37.5 The arguments go back and forth inconclusively because there is simply not the empirical evidence to settle the debate. It may never be provable in that sense. In the end it is a matter of judgment bearing in mind particularly "the size of these expenditures [on mental health], the fact that many clients are ill–equipped to protect their own interests, and the significant negative effects that inadequate mental health services can have on the entire community...." (Davidson et al., "State Purchase of Mental Health Care: Models and Motivations for Maintaining Accountability" (1991) 14 *Int. J. of Law & Psychiatry* 387, 388). As is evident from these three reports I have ended up closer to the "support" camp than the "crutch" camp. These reports endorse the regulatory roles of the DIs and DAMHS. I do not, however, see the statutory role of Director as any longer necessary or justifiable. It is time to abolish the Directorship and to redistribute the necessary regulatory functions elsewhere.

Michael Taggart
Professor of Law
26 September 1997

APPENDIX 1

STATUTORY REFERENCES TO DIRECTOR OF MENTAL HEALTH

- s. 2: definition of "Director" and "Deputy Director".
- s. 42: notice to Director of admission of a special or restricted patient to a hospital.
- s. 43: notice of discharge, transfer, etc, of a special or restricted patient from a hospital.
- s. 46: Secretary of Justice may, with the consent of the detainee, make arrangement with the Director for that person to be admitted into a hospital for care and treatment.
- s. 47: powers of Director to consent to or direct certain special patients being moved from hospitals back to penal institutions.
- s. 49: Director may direct any special patient to be transferred from one hospital to another.
- s. 50(3): where the Minister has cancelled leave granted to a special patient the Director must give a written direction that the patient be admitted to a specified hospital.
- s. 50(4): Director one of the persons authorised to take such a special patient to the specified hospital.
- s. 51(3): Director is one of the persons authorised to take a special patient (whose leave under s. 50 has been cancelled by a DAMHS) to a specified hospital.
- s. 52: Director may grant up to 7 days leave to any special patient.
- s. 53: Director is one of the persons authorised to retake any escaped or unlawfully absent patient.
- s. 54: Patients presenting special difficulties may be drawn to the Director's attention and the Director may apply to the Court to have the patient declared a special patient.
- s. 55: by virtue of subsection (2) the Director has a right to be heard in Court.

- s. 77 (3) & (4): Copy of clinical review of certain special patients to go to Director, amongst others.
- s. 78(4): Copy of clinical review of restricted patients to go to the Director, amongst others.
- s. 78(5): where the clinician recommends release from compulsory status the Director shall so direct or apply to the Review Tribunal for a review of the patient's condition.
- s. 79(10): copy of certificate of Review Tribunal to be sent to Director, amongst others.
- s. 80(4) & (5): Director receives copies of certificates of Review Tribunal in relation to certain special patients.
- s. 81: Director may seek Review Tribunal review of a restricted patient's condition and receives copy of the certificate.
- s. 91: appointment and powers of Director and Deputy Director.
- s. 95(1): Director may direct a DI to make inquiry into any matters specified in the subsection.
- s. 95(3): Full reports of all inquiries under this section, whether initiated by the DI or the Director, are to be sent to the Director.
- s. 96(4) & (5): Director may permit or require a DI to be accompanied by a doctor on any visit to any service provider; Director may appoint a doctor to advise a DI on a specific matter.
- s. 98(2): Director to receive reports of DI visits via DAMHS.
- s. 99: Director has all the powers of inspection of mental health hospital facilities as does the DGH under various statutes.
- s. 100(3) & (4): Director can direct the transfer of a patient to or from a psychiatric security institution; and can require any patient in such an institution to be photographed.
- s. 102(2): Review Tribunal can be required to report to the Director on any matter relating to its performance.
- s. 120(2): Director is one of a restricted number of persons who may lay an information for any summary offence under the Act.
- s. 127(1) & (6): Director may direct transfer of any non–special patient from and to any specified hospital or service.

- s. 127(6): if person not in fit state to be moved notice to that effect is to be given to the Director.
- s. 132(1): responsible clinician to inform the Director of death of a patient within 14 days.
- s. 133: general provisions regarding notices to be sent to or received by the Director.

Note that the Director of Mental Health is mentioned twice in the Health and Disability Commissioner Act 1994. In s. 14(2)(b) the Health and Disability Commissioner is enjoined, in exercising her functions, to consult and cooperate with other agencies concerned with personal rights, including (amongst others) the Director of Mental Health. The Commissioner was also required to consult with, and invite submissions from, the Director of Mental Health in preparing the Code of Health and Disability Services Consumers' Rights (s. 23(b)).

APPENDIX 2

[MODIFIED] EXECUTIVE SUMMARY OF REPORT TO THE MINISTRY OF HEALTH ON THE OFFICE OF THE DISTRICT INSPECTOR

1. District Inspectors [DIs] are appointed by the Minister of Health to perform important watchdog functions under the Mental Health (Compulsory Assessment & Treatment) Act 1992.

2. Broadly speaking, the statutory watchdog role performed by DIs is a form of social regulation of the State–funded providers of mental health services to mentally disordered persons who are detained for assessment and treatment. The role is justified by the extraordinary power – unique to the State – to lawfully detain and compulsorily treat mentally ill people against their will.

3. Concerns have been expressed about lack of clarity in the DIs' role, lack of accountability for the exercise of their powers and the cost effectiveness of the office. To meet such of those concerns as appear justified a number of legislative amendments and actions by the Ministry are recommended.

4. I recommend that amendments to the following effect be added to the Mental Health (Compulsory Assessment & Treatment) Amendment Bill:

- to give the DIs a discretion not to investigate a complaint under s. 75 until the internal complaint procedure is completed.

- to require a monthly report from each DI covering all aspects of that month's work.

- to recognise the power to remove, suspend or replace DIs within the term of appointment.

- to require DIs' reports of substantiated complaints to go to the service provider concerned (with a copy to the Ministry, DAMHS and THA), with

the provider being duty–bound to rectify the complaint and to so notify the patient/complainant, DI, Ministry and THA in a timely fashion.

5. I recommend the Ministry takes the following action:

• to examine the appointment and reappointment processes for DIs, giving special consideration to: how to identify the best possible candidates for appointment; how to fairly and appropriately gather the views of user groups; and how to encourage applications from suitably qualified Maori candidates and candidates from other ethnic backgrounds.

• to open up the appointments process when the next round of appointments occurs in 1999 and ask the existing DIs (who desire reappointment) to reapply and be considered along with all other applicants.

• to investigate and ascertain the cause(s) of the apparent increase in DI workload.

• to place a cap on the budget for DI salaries at the 1996–97 level.

• to monitor effectively DIs' workload and monthly and total annual billings.

• to explore, in consultation with DIs, appropriate delegation of more routine tasks to Deputy DIs.

• to ascertain from the THA the number and addresses of NGO providers of services to patients within the DIs' jurisdiction, and to make that information available to DIs in order to facilitate regular inspections.

• to obtain the consumer complaints service requirements in all purchase agreements with CHE and NGO providers of services to patients, and to make this available to DIs in each area.

• to approach the Health and Disability Commissioner again with a view to establishing a memorandum of understanding or protocol over complaints where the DIs and the Commissioner have concurrent jurisdiction.

• in consultation with the DIs, to produce a standard monthly reporting form (to be completed in a timely fashion by each DI) which contains all the information necessary to monitor the DIs' performance.

• to consider establishing a regular newsletter to DIs (and possibly others) drawing attention to matters of interest and concern.

• to take all reasonable steps to promote an understanding among DIs of their role and to assist in developing the sense of shared mission and professionalism required of a national inspectorate.

APPENDIX 3

[MODIFIED] EXECUTIVE SUMMARY OF REPORT TO THE MINISTRY OF HEALTH ON THE OFFICE OF THE DIRECTOR OF AREA MENTAL HEALTH SERVICES

1. Directors of Area Mental Health Services [DAMHS] are designated by the Director–General of Health pursuant to the Mental Health(Compulsory Assessment & Treatment) Act 1992.

2. Broadly speaking, the statutory regulatory role of DAMHS is to ensure that proposed patients and those under compulsory treatment orders receive the best treatment possible within the letter and spirit of the Act. It is a form of social regulation of the State–funded providers of mental health services to mentally disordered persons who are detained for assessment and treatment. The regulatory role is justified by the extraordinary power – unique to the State – to lawfully detain and compulsorily treat mentally ill people against their will.

3. In essence, this Report affirms the regulatory role of DAMHS under the Act and addresses issues of their employment and accountability. The practical necessity for DAMHS to operate also as employees of CHEs requires greater accountability and better defined relationships with the THA. A number of actions by the Ministry are recommended below.

4. I recommend the Ministry takes the following action:

- to instruct Parliamentary Counsel to draft a clause providing for a discretionary power in the Director–General of Health to suspend and/or remove the DAMHS designation in the forthcoming Mental Health (Compulsory Assessment & Treatment) Amendment Bill.

• to instruct the Legal Section of the Ministry to draft a flexible amending formula to permit easier adjustment of DAMHS areas for insertion into the Amendment Bill.

• to initiate discussions with the Association of DAMHS and the CHEs regarding the development of a policy of reviewing by appropriate means the performance of DAMHS every three years.

• to develop, in consultation with the Association of DAMHS, a standardised reporting form to be submitted quarterly by every DAMHS to the THA.

• to review, after appropriate consultation, the number and distribution of DAMHS around the country and to redraw boundaries accordingly.

• to initiate, and as far as necessary coordinate and oversee, discussions between itself, the THA, CHEs and the Association of DAMHS relating to the issues of relationships and funding identified in this Report.

APPENDIX 4

LISTS OF PERSONS CONSULTED

Part A: Directorship of Mental Health

Franceska Banga, Ministry
Sylvia Bell, Human Rights Commission
Associate Professor Warren Brookbanks, Auckland Law School
Dr Warwick Brunton, University of Otago
Dr David Chaplow, Forensic Services
Catherine Coates, Ministry
Dr Barbara Disley, Mental Health Commission
Gillian Durham, Director of Public Health
Hon. Bill English, Minister of Health
Richard Featherstone, CCMAU
Dr Colin Feek, Ministry
Dr Thakshan Fernando, former Director of Mental Health
Andrew Forsyth, Ministry
Gillian Grew, Ministry
Pauline Hinds, Consumer Advocate, Dunedin
John Hobbs, Ministry
Frances Hughes, Ministry
Peter Hughes, Ministry
Julian Inch, Ministry
Dr Nick Judson, Deputy Director of Mental Health
Bette Kill, THA
Retired Judge Ken Mason, Clevedon
Dr Peter McGeorge, Mental Health Foundation
Dr Wayne Miles, Waitemata Health
Ron Paterson, Ministry
Dr Karen Poutasi, Ministry
Dr Bridget Taumoepeau, Capital Coast Health
Mike Webb, Ministry
Lisa Williams, Ministry
Dr Janice Wilson, Director of Mental Health

Part B: Report on the Office of the District Inspector

Franceska Banga, Ministry
Sylvia Bell, Human Rights Commission
Catherine Coates, Ministry
Helen Cull QC, Wellington
Christine Elliott, Auckland Healthcare
Dr Colin Feek, Ministry
Anthony Hill, Ministry
Frances Hughes, Ministry
Dr Nick Judson, Ministry

Gay Keating, Ministry
Eugenie Laracy, Auckland
Stephanie Napier, THA
Ron Paterson, Ministry
Dr Murray Patton, Auckland Healthcare
Dr Karen Poutasi, Ministry
Michael Radford, Dunedin
Richard Rainey, Nelson
Philip Recordon, Auckland
Ingrid Thomas, South Auckland Health
Paul Treadwell, Karekare
Lisa Williams, Ministry
Dr Janice Wilson, Ministry

Part C: Report on the Office of the Director of Area Mental Health Services

Franceska Banga, Ministry
Dr Irv Baran, Good Health Wanganui
Vince Barry, Healthlink South
Peter Bradshaw, HealthCare Otago
Associate Professor Warren Brookbanks, Auckland Law School
Dr David Chaplow, Forensic Services
Catherine Coates, Ministry
Henry Harrison, Good Health Wanganui
Brad Healy, Health Waikato
Dr Nick Judson, Ministry
Dr Wayne Miles, Waitemata Health
Dr David Parker, HealthCare Otago
Ron Paterson, Ministry
Dr Murray Patton, Auckland Healthcare
William Rainger, THA
Dr Erihana Ryan, Sunnyside Hospital
Associate Professor Sandy Simpson, Auckland Medical School
Sue Ward, Healthcare Hawkes Bay
Lisa Williams, Ministry
Dr Janice Wilson, Ministry
Paul Wylie, Healthlink South