Safeguarding the rights of people detained for compulsory psychiatric treatment

The role of the District Inspector

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1 Introduction

...(T)he first time it was thrown at me it was described as the watchdog for consumers of mental health services...So we’re there as a safeguard to look out for, to protect, and to assist in the upholding of the rights of patients (DI #11).

District Inspectors (DIs) are lawyers appointed by the Minister of Health to ensure that the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) are carried out correctly. DIs visit hospitals, community health centres and people’s homes to assist those being assessed and treated under the Mental Health Act by providing them with information and support to ensure their rights are upheld. DIs provide an important safeguard for people who may be dissatisfied with the way they are being treated under the Mental Health Act, recognising that those subject to compulsory psychiatric treatment have lost significant rights to freedom. There are currently 34 DIs and 1 Senior Advisory DI in New Zealand.

The Ministry of Health guidelines for DIs describe them as “neither patient advocates nor legal advisors for the mental health services” and stipulate they must be independent of clinical decision-making, functioning similarly to an ombudsman. Currently, there is no research available on the development of the DI role, how it functions in practice and how it relates to legal safeguards under mental health legislation in other jurisdictions.

1.1 Aims

This project focused on the role of DIs under the Mental Health Act. The project has three related phases, each with its own objectives:

Phase one: ‘Contextualising the DI role’
Objective: To place the DI role within its historical and international legal context. What was the context in which the DI role was developed? How does the DI role compare to safeguards in place under mental health legislation overseas?

Phase two: ‘The DI role today’
Objective: To survey how the role currently functions and what support structures are in place for DIs. What are the key tasks of the DIs? What are the common challenges DIs face in undertaking the role? How do they manage these challenges? What induction and on-going training do the DIs receive? What formal and informal mentorship/peer support networks exist?

Phase three: ‘Looking forward’
Objective: To develop issues to consider which would assist DIs in the future. What practical resources would help DIs effectively carry out their duties and manage challenges in the future?

Overall, the study aims to illuminate the history of the role and its current functioning for a diverse audience, rather than provide a critical analysis of the related jurisprudence.
2 Methodology

The project employed a qualitative approach to studying the role of the DIs. A qualitative approach to research “explores and describes social phenomena about which little is presumed a priori” and generates insights into particular practices, experiences and social settings. In contrast to quantitative approaches, qualitative studies do not anticipate the effects of predetermined variables. Rather, the aim is to understand life from the perspectives of the participants within their social context.

The data collection methods used for the three phases of the project are detailed below.

2.1 Document Collection

The historical development of the DI role in New Zealand and its relationship to the international context was investigated by searching and analysing primary data such as the Appendices to the Journals of the House of Representatives, New Zealand Parliamentary Debates, government departmental documents, as well as secondary literature, international legislation and policy.

2.2 Semi-structured Interviews

To meet the objective of phase two, twenty semi-structured interviews were conducted with current DIs and two former DIs. This method of data collection allowed for the rich descriptive account of the role, taking into account different DIs’ levels of experience in the role, as well as cultural and geographical variances.

2.3 Feedback Workshops

As part of phase three, three workshops took place in Wellington, Auckland and Hamilton. All DIs were invited and 18 attended. The research team presented the preliminary findings from the study and stimulated further dialogue about how those findings might be progressed and included the project’s outline of ‘issues to consider’ for the future of the DI role.

2.4 Data Analysis

All interviews were professionally transcribed verbatim from the recordings. These were then cleaned and all participants were given the opportunity to amend, edit or delete their interview data. An inductive approach was used to analyse the data thematically. The final transcripts were read and re-read by three members of the research team independently to gain an understanding of key themes that were significant across the data corpus. This involved searching for patterns of repeated themes that were relevant to the objectives for the project. An analytical framework was then developed by the team collaboratively and used by one member of the team to then purposively code the interview data. The framework included: reasons for taking on (and continuing) the role; preparation and training for the role; how the DI’s perform the role; and the challenges in practice.

Verbatim interview extracts are presented throughout the report in italics to exemplify points being made by the research team. The presentation of the findings in this report aims to provide a snapshot of DIs practices founded on the experiences and perspectives of the DIs who took part in this project. The report does not intend to function as a definitive account of the DI practices.
2.5 Ethics

The project received ethical approval from the University of Auckland Human Participants Ethics Committee (reference number 7572). Due to the small group of lawyers acting as DIs every effort has been made in the writing of this report to ensure information provided remains strictly confidential. The names of DIs and the regions they work in are not reported.
3 Historical Overview

District Inspectors have been the watchdogs of patients’ rights since 1868. This section briefly traces the development of the DI role, identifying its origins in British law, its New Zealand peculiarities, and the changes that occurred particularly under the Mental Health Act.

The Lunatics Ordinance of 1846 required the Governor to ‘nominate and appoint some fit person or persons to be visitor or visitors of such lunatic asylum’. The more comprehensive Lunatics Act of 1868 clearly defined the role of ‘inspectors’ and a related appointee – Official Visitor. This Act set out extensive instructions for inspection of asylums including: who should undertake them, how often, what they needed to look for, and the necessity for recording observations in visitation and patients’ books. Although it did not prescribe the qualifications of an inspector, it emphasised that the person should not be a medical professional or related to a medical person.

Until the beginning of the twentieth century, qualifications required of inspectors roughly paralleled those in the English system. Under the Mental Defectives Act 1911, however, at least one inspector in each district was required to be a barrister or solicitor. While in England, inspection was carried out by Commissioners of Lunacy who were lawyers, medical persons and laymen, or by county visitors who were similar to New Zealand’s Official Visitors.

From 1911 the only official difference between the DI and Official Visitors roles in New Zealand was that the DI undertook formal inquiries into the treatment of patients or breaches of the Mental Defectives Act 1911. The DI role, therefore, assumed the status of legal watch-dog, while the Official Visitors became more akin to a friend or advocate for people confined to institutions. A DI often covered more than one hospital, whereas at least two Official Visitors (one of each gender) were allocated to each mental hospital. Nominations for DI and Official Visitor appointments were usually made by a hospital’s medical superintendent but in later decades, DI nominations came from district law societies. The challenge was to find willing people who were independent of the mental hospitals and the Public Service. People with business connections with a hospital were rejected, as were those with an ‘axe to grind’. Mental hospital superintendents were reluctant to give free access to their institutions to people who were considered ‘busy-bodies’ or who did not acknowledge ‘that our staff are doing the best in a difficult job’.

Very few changes were made to the DI and Official Visitor qualifications or responsibilities under the various amendments of the Mental Defectives Act. Under the Mental Health Act 1969, it became compulsory for every DI to be a barrister or solicitor, a requirement that continues to the present day.

Issues of advocacy and protection of patients’ rights were debated during the lengthy (1983-1992) review of the Mental Health Act 1969. These debates occurred within a global civil rights agenda that in New Zealand involved the passing of the Human Rights Commission Act 1977, the Bill of Rights Act, and the Cartwright Inquiry. The latter recommended a system of patient advocacy and the creation of a Health Commissioner. A series of inquiries into psychiatric care also raised public awareness of abuses of patients’ rights, spurring on the process of review. A heightened awareness of civil rights was already influencing Department of Health policy, with information pamphlets about DIs/Official Visitors roles being created for patients, regular meetings instituted for DIs/Official Visitors, and remuneration introduced for DIs.

Initially, the focus on rights within the Mental Health Act 1969 review came not from the Department of Health’s Review Working Party, but from the Taskforce on Revision of Mental
Health Legislation, a coalition of the Legal Information Service and the Mental Health Foundation.\textsuperscript{16} Although both groups agreed that DIs/Official Visitors should continue to play an important part in safeguarding patients’ rights and managing complaints, they differed in respect to advocacy. The Taskforce’s suggestion of an independent system of paid mental health advocates was rejected by the Department on the grounds that an advocate may act in ‘an unnecessarily adversarial way’.\textsuperscript{17}

During the 1980s, the function of advocacy became associated with the Official Visitor role which had been reinstated after approximately 10 years’ in abeyance. Reinstatement brought an expectation that Official Visitors should represent community interests and the cultural diversity of patients held under committal.\textsuperscript{18} Just prior to passing the Mental Health Act, however, Cabinet agreed to establish a national patient advocacy system that would integrate the role of Official Visitor.\textsuperscript{19}

As Dls met in June 1992, they acknowledged the increased workload under the new Mental Health Act. They appeared concerned with the lack of legal advocacy for informal patients and uncertain about how they would meet the needs of patients in the community. Rather than seeing themselves as advocates, they were in general agreement that the role was that of a ‘legal ombudsman’ who also facilitated legal services – a theme than continues through to current framework that directs Dls’ practice.\textsuperscript{20}
4 Legal Framework

Sections 94-99 of the Mental Health Act provide the legal framework for DIs and Official Visitors. The Mental Health Act retained the Official Visitor role but none have since been appointed. The Ministry of Health’s *Guideline for the role and function of District Inspectors* (Guideline) further directs DIs’ practice.21

The role of DI must be carried out by a barrister or solicitor and appointments are made by the Minister of Health. DIs hold their position for a period of three years, at which point they must reapply should they wish to continue in the role. Lawyers applying for the role are assessed using set criteria that consider the applicants’ legal knowledge and experience, particularly in the mental health sector, as well as attributes such as their ability to communicate sensitively with both patients and health professionals, make sound judgements and be aware of the cultural needs of patients.22

The Mental Health Act and *Guideline* strongly emphasise DIs must be *independent* of any mental health service within the locality they work. The Mental Health Act specifies ‘independence’ in this context as having an existing relationship with a hospital or service in the form of employment or ‘membership’.23 The Director of Mental Health describes the role as not an advocate or legal advisor and DIs are to remain strictly ‘detached’ from clinical decision-making. Instead, they are said to function similarly to an ombudsman.24

The *Guideline* outlines three core functions:

1. Ensuring all individuals subjected to compulsory assessment and treatment are “cared for in accordance to the statutory requirements of the Act”25
2. Monitoring services to ensure efficiency and assist in quality improvement
3. Conducting inquiries and investigating complaints

A core duty for DIs involves meeting with patients to provide them with information regarding their detention and their right for review and appeal. They are also required to check that documentation for all applications for compulsory assessment and treatment comply with the processes outlined in the Mental Health Act.

DIs formally commence their functions during procedures taking place under section 12(8) of the Mental Health Act, when the Responsible Clinician deems it necessary for the patient to undergo further assessment for up to 14 days. The DIs are provided with a copy of the Responsible Clinician’s certificate at which point they meet the patients and make decisions as to whether, based on the patients’ wishes, the application should be reviewed by a judge under section 16. Should the DIs consider the section 16 processes relevant, they must attempt to encourage and assist the patients – or their welfare guardians, principal caregivers, usual medical practitioners – to make an application to the court. The DI may also make the judge aware of the matter and leave it to the judge to decide if a section 16 review is necessary.

Section 14A(2) stipulates the Responsible Clinician who applies to the court for a compulsory treatment order must provide DIs with the relevant documents to enable them to discuss with the patient the next step in the process. At this point, DIs will assist the patient with locating a lawyer to appear before the court on their behalf. DIs usually only attend these proceedings should there be no legal representation or where the patient asks they attend.
DiDs also have a role in assisting patients receiving compulsory treatment in the community. The Guideline specifies that “the provision of residential care can be effectively monitored via review under section 76 and periodical review of residential facilities”.

Sections 35 and 76 of the Mental Health Act give DiDs the power to refer a case to the Mental Health Review Tribunal if they, the patient or patient’s friend/relative/welfare guardian are not in agreement with the compulsory status continuing. If the review procedure does not result in a change in legal status, the DI is required to meet with the patient again to see if he or she would like to appeal the Mental Health Review Tribunal’s decision.

Section 96 further instructs DiDs to inspect each of hospital or service where patients are being assessed or treated as an inpatient at least once a month. Outpatients should be visited at regular intervals by DiDs at least four times a year. The Guideline suggests that a ‘service’ under the Mental Health Act does not normally include residences or boarding houses and that these are not places DiDs must routinely inspect unless a patient has made a specific complaint. Non-Government Organisations capable of taking patients under the Mental Health Act are included for inspection. When making their visits, DiDs must be permitted to access any part of the service and any patient, even if admitted informally, as well as any documentation related to these patients. They are required to report on each inspection within 14 days to the Director of Area Mental Health Services and provide a monthly report to the Director of Mental Health.

Complaints regarding breaches of patient rights are referred to DiDs under section 75. They must investigate the complaint and, if the matter cannot be resolved informally, DiDs report to the Director of Area Mental Health Services, detailing aspects they considered in their investigations and any recommendations. The Office of the Health and Disability Commissioner may also refer a complaint to a DI when it relates to a patient detained under the Mental Health Act.

Section 95 gives DiDs the power to conduct inquiries into breaches of the Mental Health Act with focus on the role of the service. The Guideline provides examples of both ‘narrow’, as well as the more serious section 95 inquiries DiDs may undertake. During a ‘narrow’ inquiry, a DI may examine “aspects of a service’s quality being compromised...”. Large scale inquiries consider major incidents, such as a suicide or assault. A DI, the Director of Mental Health, or the Minister of Health may initiate inquiries and the Guideline suggests that “formal section 95 inquiries should generally be limited to circumstances where there is clear evidence of outstanding issues that are not being addressed by the mental health service”. On receiving the report on the inquiry, the Director of Mental Health decides what form of action to take. This usually involves asking the District Health Board to address the particular issues through internal review and follow-up.
5 International Context

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) calls for a codification of broad rights to advocacy in relation to decision-making under mental health legislation. The role of DI sits well with the UNCRPD, particularly in its ability to contribute to meeting articles 12 (equal recognition before the law); 13 (access to justice) and 14 (liberty and security of a person). The First New Zealand Report on Implementing the United Nation Convention on the Rights of Persons with Disabilities describes the importance of the DI role in visiting facilities, reporting and conducting inquiries into service issues and complaints alleging breaches of a patient’s or care recipient’s rights. DIs also may an important role in assisting New Zealand to meet its obligations under the Optional Protocol to the Convention against Torture (OPCAT). The monitoring mechanisms under OPCAT are used to monitor places of detention, which includes secure facilities under the Mental Health Act. Under OPCAT, there are five National Preventive Mechanisms: the Human Rights Commission, the Office of the Ombudsman, the Office of the Children's Commissioner, the Independent Police Conduct Authority, and the Inspector of Service Penal Establishments. The visitations, inspections, complaint investigations and inquiries functions of the DI role allow for the National Preventive Mechanisms to be advised of any breaches of rights or concerns from DIs in relation to staffing, use of restraint and seclusion and standards of facilities.

Readings of international law suggest the DI role is unique. Although various jurisdictions permit access to advice regarding individual’s legal rights while being detained under mental health legislation, this is not a guaranteed statutory service provided solely by dedicated lawyers. Table one (located at the end of the report) provides a summary of independent advocacy roles across the United Kingdom and Australia. It indicates that some States in Australia have statutory provision for two levels of advocacy for people under compulsory assessment and treatment. Public advocates, which operate in Queensland and Victoria, are charged with promoting patients’ rights and monitoring service provision but do not undertake investigations of complaints. Community visitors, on the other hand, can conduct inquiries and investigate complaints as well as making regular visitations and generally monitoring service provision. New South Wales, Western Australia, Tasmania, and Australian Central Territory all have official visitors, who have much the same function as DIs in New Zealand. They have the ability to handle complaints, inspect and monitor facilities, and assist patients’ access to advocacy. Although official visitors are required to have some form of professional qualification in Tasmania and Australian Central Territory, there is no specific requirement for any of these roles to be undertaken by a lawyer.

Currently, ‘Independent Mental Health Advocates’ are available to patients detained for psychiatric treatment in the United Kingdom. They aim to support patients to understand and exercise their legal rights. With the implementation of the Mental Capacity Act 2005 (United Kingdom), a new statutory form of advocacy was also established with the introduction of ‘Independent Mental Capacity Advocates’. The function of this role is to provide support, representation and safeguarding of the rights of those who lack capacity to make decisions and have no existing representation. Both roles are not performed by lawyers; rather they are provided by carers, mental health social workers, nurses and self-advocacy networks, although specialised training must be undertaken prior to practising in either roles.
6 District Inspectors’ Current Practices

This section presents the findings of a study on how the role of DIs works in practice. It draws on material generated from 22 semi-structured face-to-face interviews with DIs throughout 2011. Excerpts from the interviews will be used to provide a descriptive analysis of the background of DIs, the functions of the role, and how they handle inquiries and complaints.

6.1 The Background of District Inspectors

Most of the DIs had been in the role for over three years, with four having appointments longer than 10 years. The majority of DIs had extensive experience in mental health law and continued to work with vulnerable individuals in their private practices, making them well placed to fulfil the requirements of the role. For example, many DIs had been on their local District Health Board roster of lawyers accessible to mental health patients and continued to work within the areas of family law, criminal law, administrative law, commercial law, and human rights. A large majority worked with people subject to the Protection of Personal and Property Rights Act.

The Guideline specifically addresses the Ministry’s intention to recruit DIs with the competence necessary to meet the cultural needs of patients. There are few DIs from Māori or Pacific background, which perhaps reflects difficulty in recruiting from these ethnic groups. The DIs reported that although it might be advantageous to have DIs of other ethnicities, specifically Māori, of greater importance was to have DIs who match the population base in each regions. DIs reported working with a range of culturally diverse patients and some found it particularly problematic when working with migrants who have little or English language skills. In these situations, the services of an interpreter were required which involved more time to organise (DI #18).

6.2 Defining the Role

The DIs emphasised the independent nature of their role, often illuminated by their descriptions of what the role does NOT involve:

To be a watchdog ombudsman type of person, and that is also intertwined with being, not an advocate, it’s less than being an advocate, but to facilitate advocacy for a client. To ensure they have an advocate (DI# 16).

One of their main challenges in achieving such independence involved acknowledging that the DI role is very different from acting on patients’ behalf as their lawyers:

The DI role is to ensure that the rights of the patient are protected, and amongst those rights is the right to treatment...the lawyer’s role though, is different in that they must follow the instructions of their client. And if a person wants to be out of the hospital, not taking treatment, then they need to pursue rigorously and vigorously the person’s right to be heard by a judge and to try and be discharged from the MHA (DI #18).

Rather than strictly following the patients’ instructions, the DIs focus on facilitating access to information and advocacy.

Being perceived as independent of the District Health Board was also important to the DIs and they strived to avoid being drawn into discussions beyond their role. Where the DIs had been
practising in the same region for a long period, however, clinicians at times would request their support for clinical decisions:

My role is not to make decisions about patients, that’s the doctor’s role and the nursing staff’s role…sometimes, you know, they want you to agree with them and I might in fact if I turned up, agree with them. But that is not my role (DI #2).

The DIs also described instances where clinical staff asked for their legal advice:

It becomes a bit grey when they’re asking us for legal advice, are we allowed to do this? Because they have legal advisers and we’re not the hospital legal advisors… (DI #22).

Many DIs resisted being allocated their own offices at the local hospitals they visited regularly in an effort to maintain a clear boundary between themselves and the staff at the District Health Board.

6.3 Induction and Training

A requirement for training, induction or on-going professional development for DIs is not specified in the Mental Health Act or Guideline. Support on commencing the job appeared to be variable for those interviewed. For some DIs, a half-day formal induction was provided while others received less preparation for the role. The expectation that new appointments begin as soon as the previous appointments end meant there was often little time for preparatory activities to take place. Instead, much of the learning took place on the job and the new DIs gained the support they needed from informal relationships with experienced DIs:

...And so yeah it wasn’t, it was, some of it was learning on your feet but having said that the other DIs in the area, and other experienced DIs were fantastic. And they were probably the biggest thing, it wasn’t formal training, but I’d ring people up, and ask people, and that’s often the best way (DI #1).

The backgrounds of DIs meant they were also well placed to take on the role initially:

A big part of what you do as a DI is about people relationships, making the relationships with patients and also we have to deal with Director of Area Mental Health Services, the Responsible Clinicians and other clinical staff. I think, especially family law, that’s a big part of what you do as well. Also I think the property work I do, you have a high degree of care and attention to detail...[which helps] with part of what we do as DIs ((DI #14).

As DI# 14 suggests, some of the work the DIs did cannot be taught through formal training. Rather, learning on the job was most helpful to them, alongside being supported by colleagues.

Regionally, the DIs met every three months and in some larger cities monthly. Informal group email correspondence also tended to take place allowing the DIs to discuss current issues they faced. On-going support was also provided to DIs by way of six monthly national meetings hosted by the senior advisor DI and the Director of Mental Health at the Ministry of Health. This meeting runs across two days and includes discussions of regional and national issues regarding legislative changes and relationships with the police, courts and mental health services. Training was also provided, whereby presentations were often given by clinicians, legal academics, consumer advocates and other relevant bodies. The DIs discussed how their strong relationships with the Senior Advisory DI and the Director of Mental Health also provided valuable support.
6.4 Core Functions

The three core functions outlined in the Guideline are achieved by the DIs through visitations, inspections, complaint investigations and inquiries.

6.4.1 Document Checking and Visitations

The study indicated that there is no set routine for visitations. To fulfil this role competently, the DIs needed to be flexible enough to adapt to the different needs presented each week. Document checking and visitations were the priority for all DIs but practices varied according to the location. DIs working in larger cities tended to have a more structured approach to document checking and visitation in order to fit their work within the 30% time requirement specified by the Ministry of Health.

The first job for DIs was document checking. The Mental Health Act administrators provided the DIs with the relevant documentation. This usually included the certificates, the assessment and other documents related to the five day period of detention.

[The MHA administrators] send me the paperwork and the first part of my job is checking the paperwork's been done correctly and following it up if it hasn't been done correctly (DI #1).

These DIs also thoroughly read all the clinical notes attached to the patients’ files. This information allowed them to have substantial background knowledge on the patients prior to meeting. A particular concern at this point was identifying the patients’ relationship status with their families/whānau and whether consultation had taken place with families/whanau during section 7A of the assessment phase. The DIs also had informal meetings with clinical staff to gain further insights into the current mental state of the patients and any issues the staff members may want addressed.

When meeting with patients initially, the DIs ensured that they discussed the independent nature of their role and explained the patients’ legal right to a section 16 hearing:

[I say] I am not a doctor, I’m not a nurse, I’m not paid by the DHB [District Health Board] to come and talk to you... then you explain to them about their rights to ask for what’s called a Section 16 hearing (DI #2).

The DIs again advised patients of their right to a Section 16 review following the next assessment after 14 days. In both instances, the DIs also provided patients with a list of publically funded lawyers and in some instances facilitated the appointment of a lawyer.

Following the initial meeting with patients, some DIs checked in with Mental Health Act administrators for any further relevant records. They also responded to general queries from other patients, their family members and staff on the ward (DI #20). All DIs had regular meetings with the clinical directors and Director of Area Mental Health Services in their regions.

Patients in the community are contacted by DIs when they have received a copy of a section 76 certificate of clinical review. The DIs used a standardised letter that described their role and encouraged patients to contact them if they would like to challenge their legal status. People under inpatient orders are also able to apply to the Mental Health Review Tribunal for review of their condition. If patients chose to have their condition reviewed, the DI met with them to explain the process and helped them to apply to the Mental Health Review Tribunal.
So if the clinician says they should remain under the Act, they sign a certificate to that effect, they’re supposed to give a copy of that to the patient, and to various other places. And one comes to me as the DI, and so we then make contact and say look, you’ve got the right to apply to the Mental Health Review Tribunal if you wish to do so and I can explain that to you in person if you want to go through that with me. Frequently people are quite happy with their status, frequently people will ring you up and say I wanna do that, I want to get off the Act. So you make whatever arrangements to meet and discuss that (DI #10).

Some DIs believed it was appropriate to advise patients of the likelihood of discharge by the Mental Health Review Tribunal. Other DIs did not see it as their role to predict the likelihood of discharge:

But [if] it’s still clear they won’t succeed, I’ll rely on the lawyer. Then they have to see a lawyer and the lawyer will give them legal advice about the chances of success. It’s not for me to pre-determine whether they’ll be successful or not (DI #18).

In other instances, the DIs informally rectified patients’ issues and thereby avoided a Mental Health Review Tribunal hearing:

...(L)ast year I had a guy who did want to be discharged from the Act. And so I met with him and invited his responsible clinician to meet and discuss their points of view as to why he shouldn’t be under the Act anymore…it seemed to me that this guy really, he just wanted to live somewhere of his own choosing, he didn’t want to be in supported accommodation anymore…I could understand the clinician’s point of view that really he tends to get isolated; it is good for him to have contact where he was, all very sensible. BUT actually, it had gone beyond the period of time where they should be able to impose that upon him...so we just had that discussion (DI #10).

6.4.2 Inspections

The DIs tended to carry out inspections in combination with the visitation duties described above. Several DIs emphasised that they preferred to make unannounced inspections at random, so that service providers did not expect their presence on a particular day:

I don’t want the DHB [District Health Board] to know when I am coming because otherwise things might be tidied up. ...I’ll go in and it could be three times a week, it could be twice a week. It just depends....I’ll often go in at night or on the weekends...it’s nice to see on the weekend how they are operating because the staff are different, so I want to see how it feels...how people are feeling....are they operating ok? (DI#5)

The inspection of facilities generally involved observation of the staff and the general state of the service. DIs also checked incident forms and registers regarding seclusion, restraint, and absence without authorisation. When reviewing the forms and registers, the DIs looked for missing information, but also patterns of problematic practice, such as repeated use of seclusion:

...And often you’ll find that there will be something in the incident forms that hasn’t made it to a register, or something in a register that hasn’t made it into the forms. I’ll also look at the seclusion register and look for patterns. If someone’s ending up here all the time, [I will ask] what’s going on? Is this person being put in seclusion as a punishment? Or is this person being put in seclusion because there are insufficient staffing numbers and they can’t one-on-one the person? (DI #15).
This same DI often inspected other aspects of the service, including observation of staff behaviour and standards of cleanliness:

> For instance, are there staff circulating in all the areas of the ward? Or are they congregating in the nurses’ station, chatting about Shortland Street and drinking cups of tea? ...So I’ll just note things like that for my report and in my discussions with the Director of Area Mental Health Services that the staff are not circulating, there’s no one sitting out there. There’s no one monitoring movements... And yeah, I mean, I wander down into seclusion rooms and, you know make sure that they’re clean, and that the facilities are being well maintained. I look for, yeah make sure the toilets are flushing, I mean I take a wander through each month (DI #15).

The above quote indicated the potential breadth of factors DIs may consider in undertaking their inspections.

Regarding patients who resided in the community, DIs reported that visitation was sometimes challenging. In part, this was attributed to a large number of community-based patients, limited time and large geographical areas:

> And I guess the thing that I would have to confess to not doing as thoroughly as I should and that is the Act requires that we visit any other hospitals or facilities in which patients are residing. And so that includes going and seeing people who are under the Act who are living in accommodation provided by the mental health providers. And it was always for me an effort, to get out and go and visit those houses and see them and report on them (DI #3).

Additionally, some DIs devoted substantial time to locating community patients because the contact details they had been provided by the District Health Board were incorrect.

### 6.4.3 Complaint Handling, Investigations and Inquiries

The DIs described a variety of complaints that they addressed on a daily basis from patients, their families and clinical staff. Patient complaints ranged from low level issues, such as food complaints or wishes to have certain medication increased, to requests for a change in the treating psychiatrist or service provider. Some DIs had interactions with informal patients if they had contacted them with a complaint.

DIs also investigated concerns about the cultural needs of patients. In catering to the needs of Māori patients, a DI noted that this was met by reading the patients’ case notes to ascertain what the management plan included and whether this involved a referral to a kaumātua or the services provided by Māori social workers. In some cases information sharing is extended to the whānau which may occur where communication with the medical team has become strained, or it may mean checking that the whānau are aware of the availability of resources (i.e. whānau room). Many DIs reported that patients complain about the ethnicity of the health or disability service provider. Although there was recognition that sometimes the complaint was based on patients’ racial prejudice, there were examples that non-New Zealand providers lacked cultural understanding. One DI reported that a foreign-trained psychiatrist was dismissive of the cultural beliefs of a patient who believed he or she was cursed (DI #4).

The DIs approached most types of complaints in an informal manner initially, avoiding a formal section 75 investigation if possible:

> For example you can discharge the role quite efficiently, so if somebody makes a complaint you can write a whole bunch of letters and have formal hearings, and make a
big deal out of it. Or you can sort of deal with it in an informal way and make sure that things are resolved and that is my preference…I find complaints can be dealt with in a reasonably sort of cost effective way (DI #7).

The informal approach to addressing complaints tended to work well due to the strong relationships DI had forged with the clinical staff:

...If they’ve got an issue, then I would go and talk to whoever might be their doctor or their nurse or whoever and see if I can resolve it and it’s amazing how receptive the staff are to suggestions...sometimes just talking through the issues you can resolve them. I generally find just an informal sort of review works (DI #1).

Finally, it was suggested that in larger areas where the workload for the DIs was high, informal means of complaint handling were a less time consuming than a section 75 or 95 investigation:

We do 75’s but again the workload of the [region x] DIs is so high that to undertake a formal section 75 inquiry, which is so time consuming, is less likely than an informal investigation, reporting, and a discussion (DI #18).

Nevertheless, the DIs described a number of section 75 inquiries. One example involved a member of the multidisciplinary team making a confidential complaint to the DI about debatable practice by the crisis team. The team often attended mental health emergencies without a Duly Authorised Officer present. Consequently, the team would have to travel back to the hospital to pick up an Duly Authorised Officer to transport the patient in for assessment under the Mental Health Act. This led to significant delays. The DI investigated the complaint and identified a lack of nurses who were approved as Duly Authorised Officers within the service. The issue was then raised by the DI in a meeting with the clinical director and Director of Area Mental Health Service. As a result, the nurses’ roster was adjusted to ensure that an adequate number of Duly Authorised Officer approved nurses were always on duty to cover crisis team call outs.

A second example was also a complaint given in confidence from a member of the multidisciplinary team and related to the wrongful dispensing of medication:

... (U)nder recommendations from Pharmac and the local chief pharmacist’s protocol, [dispensing should] have been only done in the hospital. It shouldn’t have been done in the community where he was living. I looked at the file and saw he’d been titrated at 3 times the recommended daily increases and that breached the protocol (DI #2).

The DI then became aware that the patient had been admitted voluntarily as a result of the high levels of medication being administered. Although not formally under the jurisdiction of DIs, the Ministry supported the DI to pursue a resolution with the clinical director to ensure this kind of practice did not recur:

And so when I checked that, the chief pharmacist and the unit manager, and the clinical director, looked at it very carefully, spoke to the psychiatrist and assured me that they would do everything they could to make sure that didn’t happen again. And to my knowledge in the last four or so years it hasn’t happened again (DI #2).

The DIs related other examples of serious assaults on staff, suicides by patients on 10 minute watches and generally problematic practices on wards:
(A) patient had been admitted to hospital by police and was wearing plastic handcuff at the time and he struggled as he was going into the ward and his struggling continued into the bedroom. While he was struggling on the bed, police also put cuffs on his legs and there were four or five mental health staff around. He remained in handcuffs and leg cuffs for most of the night and that one wasn’t one I thought could be resolved informally because it was one where something really extraordinary had happened without anyone really questioning why (DI #7).

Following this DI’s investigation, a report with constructive critique of the practice was well received by the clinical staff.

Some section 75 inquiries were instigated by a referral from the Office of the Health and Disability Commissioner. One example related to a series of patient assaults on clinical staff within a mental health unit. The DI was asked to launch an investigation which resulted in the introduction of a policy about the proper steps for reporting assaults against clinicians to the police.

The DIs identified a general lack of knowledge about these complaints processes. Although patients and families/whānau were provided with an information package on the role of DIs, it was felt by some that many complaints were directed towards the Office of the Health and Disability Commissioner when they could be lodged directly with DIs:

... (T)hey don’t know that they can make a wider complaint and have a wider investigation of it. And I think on occasion DIs need to hear about those complaints. And they haven’t been told they could call a DI. And I think that extends to families too, who are unhappy about the process or some aspect of the process and don’t know about DIs (DI #18).

DIs then usually received a referral from the Office of Health and Disability, which they then followed up.

Clinical staff also did not always understand the function of DIs. This had the potential to create difficulties when handling complaints:

I think sometimes lack of understanding about what our role is...sometimes staff can’t understand that we’re not lawyers. We are lawyers, but we’re working in a different role. So that we are entitled to access written documents, we don’t have to have consent from the patient...that, you know, we’re carrying out a statutory function. I suppose sometimes resistance from people when we’re investigating complaints. They don’t want to give the information to us (DI #14).

The Office of the Director of Mental Health Annual Report details there were between one to four section 95 inquiries per year from 2003-2011. This gives an average figure of 1.6 section 95 inquiries per year in this same period. A small minority of the DIs interviewed had completed a section 95 inquiry, so examples from this research were scarce. One example, however, illustrated how wide ranging section 95 investigations are. A recent inquiry conducted by a DI investigated clinical issues and systemic service failure in a District Health Board. This related to serious events (including serous self-harm and suicide), as well as the operation of statutory roles. Most DIs suggested section 95 inquiries were costly and instigated after serious events only, usually at the Ministry of Health’s request.
6.5 Other Challenges

The DIs described a variety of other challenges that they faced in undertaking the role. These included practical challenges and systemic challenges.

6.5.1 Practical Challenges
The Guideline suggests lawyers spend 30% of their time carrying out DI duties. Although most agreed they were easily able to abide by the Guideline, in certain situations it was difficult. The DIs described how they were careful to monitor themselves to ensure they did not go over the expected amount of time:

*We’re supposed to only do one third, that’s what the guidelines for district inspectors is. But the reality is that you, it would be very easy to make it significantly more than 30% of your workload. You can delve into the circumstances surrounding someone’s admission, or their, the Section 7A consultation with family, you know at length really. So I have to be careful that I do keep it within the third, and I would probably go over it, but that’s what the Ministry of Health wants us to do (DI #18).*

Many DIs explained that managing their time could be impacted by external factors such as travelling times. This was particularly problematic in cities that experienced heavy traffic problems and for rurally based DIs that have to cover extensive areas. Some DIs explained that at times it was difficult to balance their legal practices with the tasks of the DI, but in most cases this could be managed by having another DI provide cover where possible. In some instances it was necessary for the DIs to work weekends and outside business hours to complete their tasks.

Other practical challenges could be reduced if the Mental Health Act administrator established a more efficient administrative system. As one DI stated: “*(S)he’s a very good administrator so she’s very good at keeping, she keeps the doctors up to date with all the people who are at different stages in the Mental Health Act*” (DI#2). Several DIs remarked, however, that periods of relative efficiency (or inefficiency) could be linked with the standard of the Mental Health Act administrator.

When making their visitations to inpatient units, DIs had varying experiences in accessing an office or desk, telephone, and computer to check documents, one of their core functions. While some DIs had these resources, others had limited resources. Some had to share and/or step aside when clinical staff needed access to resources. At times this was because staff did not appreciate that statutory nature of the DI role.

6.5.2 Systemic Challenges
A number of systemic issues contributed to the challenges DIs faced. Several were issues which could not be addressed by s95 or s75 inquiries. These included inadequate resources and gaps in services. Resourcing issues cited by DIs included shortages of clinical and cultural staff and beds, as well as the condition of older facilities. A DI reported:

*I mean a recurring theme is the congestion on the ward that is caused by a lack of resources in the community to provide for patients who would otherwise be discharged if the services were there (DI #15).*

DIs expressed growing concern for those who are particularly vulnerable such as older people. One DI wondered whether older patients were receiving adequate care:
I worry about an elder, you know in old people’s homes. I worry about the disabled. I’m not sure what organisations are there for their purposes but for some older people I think things don’t happen as they should (DI# 5)

Other DIs noted that they observed many people who were not subject to the Act (i.e. informal patients) but would benefit from DIs’ assistance:

… (W)e are told to constrain ourselves to people subject to the Act. So if an issue comes up with someone else, it’s kind of outside our, we can see it and I think that’s a budgetary limitation. And I understand that but there are some gaps (DI#5).

A DI reported concerns that residents of general rest homes might not receive adequate care if the facilities are not adequately monitored and managed (DI#8). This DI suggested the solution might lie in an integrated approach:

The biggest issue is realising that there is a tension between understanding the Act and between organisational change. Much of the change needed is impossible because of lack of resourcing – staffing, beds, etc. These issues need a systematic response to fix the organisation and it is frustrating and something the Ministry needs to address. The DI role may be seen as ineffective where the big issues identify that there are too few staff and many more service users on medications that are new and where holistic approach is often not possible. How can this change? By having everyone from service users, their supports, health professionals and the DI all at the table to cooperate and integrate (DI #18).

6.5.3 Accessing Lawyers
Where a patient required a lawyer, there was variance in how this was organised. In most cases, the DI would contact a lawyer from a roster of lawyers experienced in mental health law. If the patient had a preferred lawyer, the DI would contact that person. In contrast, some DIs preferred that the mental health administrators organised the allocation of a lawyer, thereby maintaining DIs’ independence.

Furthermore, DIs expressed the importance of having a pool of experienced mental health lawyers in the future. Some DIs noted that the changes to legal aid funding may impact upon lawyers entering and continuing in this field:

But so often the patient is on benefits and in need of legal aid. And getting my young staff across that hurdle to be able to get qualified to do mental health work is onerous and costly for us as a firm (DI#3).

Some regions had already experienced difficulties in obtaining approved legal aid lawyers, which could lead to higher costs and delays in getting lawyers from other regions to fill the gap.
7 Discussion

DIs have played an important role as watchdogs of patients’ rights since 1868. New Zealand currently paves the way within the context of international human rights. Although other jurisdictions may have similar roles, a statutory provision of dedicated lawyers who meet with all patients under the Mental Health Act and check their documentation is not mandated in other countries. The DIs that took part in this study were passionate about this mandate and enjoyed working at the interface where civil liberties meet public interests.

The daily practices of the DIs were by and large flexible and tailored to varying demands on specific days. Heavy workloads coupled with the 30% time requirement, impacted on how the DIs structured their time. Generally most DIs completed the three core duties of document checking and visitation, inspection and complaint handling in combination over the course of a day, although the first duty usually took precedence. The attention to detail in their inspections and the variety of complaints described by the DIs illustrate the wide scope of the role. The DIs played an important role in ensuring the service is of an appropriate standard.

DIs in this study, however, faced challenges in undertaking their duties. Clinical staff members’ misunderstandings about the nature of the role made it difficult for DIs to instil an image of themselves as detached from clinical decision-making and as distinct from legal advocates. At times, patients, their families and clinical staff lacked the necessary information to know the DI role existed and what it entailed. Some DIs felt that this led to complaints going unheard. This is particularly relevant in the community where patients were visited less frequently than formal, hospitalised patients.

DIs were committed to addressing complaints through informal means where possible. Most often they did this successfully, thus reducing patients’ potential stress during formal review and complaint procedures. The DIs had investigated a diverse range of breaches of rights through section 75 inquiries. These included complaints covering serious incidents of staff security and safety, wrongful dispensing of medication and allegedly disturbing clinical practices. Generally, services were supportive of these inquiries, but again the lack of understanding around the role in some instances made it difficult for the DIs to access the information they needed.

The Mental Health Act prioritises the community as the site for compulsory assessment and treatment. At the time the Mental Health Act was passed, DIs raised concerns about how well they could meet the needs of patients in the community given the heavy workload largely focussed on mandated responsibilities in the inpatient setting. They described their functions as similar to an ombudsman rather than an advocate, and wondered how informal patients’ rights would be upheld. It appears these issues are still relevant today. Some of the DIs discussed difficulties in completing visitations to community based mental health services. Their concerns are reinforced by the figures that indicate a rise in the use of community treatment orders. Between 2005 and 2008 the national average rates of use of community treatment orders was stable at between 57 and 60 per 100,000. In 2009, however, the rate increased to 63 per 100,000, and in the following years to 76 (2010) and 83 (2011).12
7.1 Issues to Consider

Three issues for further consideration in the on-going functioning of the DI role have been identified through this project.

7.1.1 Meeting the Needs of People in the Community

This study has found that it is a challenge for many DIs to meet the needs of people in the community. **Specific issue to consider:** An investigation into how DIs can be supported to respond to patients in the community and vulnerable people who reside in residential facilities, particularly older adults.

7.1.2 Training and Professional Development

The study found that training on commencing the job of DI to be variable. Informal networks and learning on the job with direct support from colleagues using a buddy system appeared most helpful to new DIs. On-going support was provided from regional network and national meetings. **Specific issue to consider:** The formalisation of a buddy system, followed by continued and regular contact with a group of experienced DIs, for all new DIs so that they have optimum induction.

7.1.3 Promotion of the DI role

The DIs discussed how at times patients, their families and clinical staff members misunderstood the nature of the role. One of the implications of this is the concern that some complaints are going unheard, particularly in the community where DIs are not in as much contact with patients. **Specific issues to consider:**

- Improve information for service users and their family/whānau on the role of the DI (e.g. flyers, posters, video, website, detailed business cards)
- Disseminate information to patients and their family/whānau at various stages of admission.
- Encourage wider promotion of the role to community groups (e.g. Mental Health Foundation, Mind and Body).
- Formally acknowledge education about the role by current DIs to clinical staff
8 Conclusion

This study explored the functions of DIs and placed them within historical and international contexts. The current role emerged within a milieu of heightened global awareness around human rights. Today the role continues to strongly support New Zealand’s attempts to implement the United Nations Convention for the Rights of People with Disabilities. Most importantly, the DI role contributes significantly to the aspirations of the Mental Health Act to strike a balance between individual rights to freedom and the state’s responsibility to protect its citizens. In the words of a DI:

*If you need to be in there [hospital] and you need the support it can be very good. But if you’re in there and you get the support that you need and feel as if you want to be off the Act, it’s very difficult to get out of it unless there’s a DI hanging around (DI #14).*
<table>
<thead>
<tr>
<th>Role title</th>
<th>Country/State</th>
<th>Functions</th>
<th>Profession qualifications required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public advocate</td>
<td>QLD, VIC, Australia</td>
<td>Promote rights</td>
<td>No specific requirements mentioned in State legislation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor service provision, education programs and facilities</td>
<td>No investigations of complaints</td>
</tr>
<tr>
<td>Community Visitor/Community Visitors Program</td>
<td>QLD, VIC, NT, South Australia, Australia</td>
<td>Conducts inquiries, investigates complaints</td>
<td>No specific requirements mentioned in State legislation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Makes regular visitations and monitors service provision</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Refer serious issues to the Office of the Public Advocate</td>
<td></td>
</tr>
<tr>
<td>Official visitors</td>
<td>NSW, WA, TAS, ACT, Australia</td>
<td>Refer serious issues to appropriate authority</td>
<td>NSW requires Medical practitioner Registered psychologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inspect/monitor facilities Act as patient advocate</td>
<td>Or other suitable qualification; ACT requires Legal practitioner</td>
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<td></td>
<td></td>
<td></td>
<td>Medical practitioners Nominated by a body representing mental health consumer services</td>
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<td></td>
<td></td>
<td></td>
<td>Relevant experience/skill</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No specific requirement for other States</td>
</tr>
<tr>
<td>Independent Mental Health Advocates (IMHAs)</td>
<td>England, Wales</td>
<td>IMHAs – Help patients understand and exercise rights under the Mental Health Act. Support patients in decision participation.</td>
<td>Both IMHAs and IMCAs require industry qualifications in order to practice</td>
</tr>
<tr>
<td>Independent Mental Capacity Advocates (IMCAs)</td>
<td>England, Wales</td>
<td>IMCAs – Provided for over 16yr olds who have no other representation and who lack capacity to make informed decision regarding their care. Ensure patient’s human, civil and welfare rights are respected through independent representation.</td>
<td></td>
</tr>
<tr>
<td>The Lord Chief Justice’s Visitors Medical Legal General</td>
<td>Northern Ireland</td>
<td>Visitors appointed to visit patients under Mental Health Act when investigation into matters concerning patient’s ability to manage their property and affairs. Visits are usually undertaken by General Visitors, unless the Court requires Medical and/or Legal information regarding the patient</td>
<td>Medical – Requires a medical practitioner who has special knowledge and experience of cases of mental disorder Legal – Barrister or solicitor with at least 10 years practicing experience</td>
</tr>
<tr>
<td>Independent Advocates</td>
<td>Scotland</td>
<td>Supports and enables patient to express views regarding their treatment and care</td>
<td>No specific qualifications, although training provided by advocacy groups</td>
</tr>
</tbody>
</table>


4 Giacomini, M. K. (2001). The Rocky Road: Qualitative Research as Evidence. Evidence Based Medicine, 6, 4-6.


6 The Lunacy Ordinance 1846, cl 1.52

7 In both countries, an Official Visitor initially had to be a justice of the peace but New Zealand dispensed with this requirement in 1894.


10 For example, List of District Inspectors and Official Visitors 17 August 1939 H1 Box 124 30/39 30288 Mental Health-Visitors-District Inspectors-General 1919-1965 ANZ Wellington.

11 Memorandum from Frank Hay (Inspector-General of Mental Hospitals) to Hon Russell 25 March 1919; Letter from Theodore Gray (Inspector-General of Mental Hospitals) to Minister of Health 22 September 1930; Letter from HM Buchanan (Medical Superintendent Auckland Mental Hospital) to Director-General of Mental Hospitals 11 July 1944 H1 Box 124 30/39 (30288) Mental Health-Visitor-District Inspectors-General 1919-1965 ANZ Wellington.

12 Memorandum from Frank Hay to Hon Russell 29 March 1919 H1 Box 124 30/39 (30288); Extracts from Recent Criticisms, April/May 1938 H1 Box124 30/39 (30288) Mental Health-Visitor-District Inspectors-General 1919-1965 ANZ Wellington.


15 Circular letter from Stan Mirams (Director of Division of Mental Health) to Medical Superintendents, 16 July 1979 ABQU W4452 632 Box 140 30/39 (52663) Mental Health-Visitors-District Inspectors 1976-1980 ANZ Wellington; Memo from Director-General’s Meeting 12 February 1982 ABQU 632


18 Full Submission of the Taskforce on Revision of Mental Health Legislation April 1985, p 23, ABKZ W4149 Box 123 7/1/28 part 1 Acts, Bills, Regulations etc, Mental Health Act 1983–5 ANZ Wellington.


21 Ministry of Health Guideline for the role and function of District Inspectors (MOH, 2012).

22 Ibid, p 1.

23 See the Mental Health Act, s94(2)

24 Ministry of Health Guideline for the role and function of District Inspectors (MOH, 2012) at 1.


27 See the Mental Health Act, part VI.


31 The DIs are not required to see patients before section 12 of the Mental Health Act. Some DIs choose to meet with patients during the 5 day period of assessment because they have a right to a section 16 review (DI #15). Additionally, if they receive a complaint from a patient at this stage of assessment they would also go and see that patient. (DI #18).
