

**MENTAL HEALTH LEGISLATION IN NEW ZEALAND FROM 1846 TO DATE:
A DISCOURSE ANALYSIS**

**A thesis presented in partial fulfilment
of the requirements for the degree of**

Master of Nursing

at the

Eastern Institute of Technology

Taradale, New Zealand

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2010

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ABSTRACT

This thesis presents an analysis of the legislation pertaining to mental health in New Zealand dating from 1846 to the present. It is based on discourse analysis (Gee, 2005; Given, 2008; McClosky, 2008; Stevenson, 2004), which is grounded in an historical genealogy (Kendall & Wickham, 1999; Slembrouck, 2006). Mental health problems have probably been around since the birth of humanity. However, legislation around the issue is a fairly recent phenomenon.

Historically the gradual trend towards involuntary incarceration ensued from the various laws that came into being in the United Kingdom. A study of those laws is pertinent because the early New Zealand legal system directly mirrored what had been happening in the U.K. Since 1846 there has been a series of legislation enacted in New Zealand that deal with mental health issues. This study focuses on the nomenclature of those laws and their attempts to define what constituted lunacy, mental defect, and latterly mental health. None of those definitions have been totally satisfactory and demonstrate inconsistencies, as well as opposition to other laws.

The thesis highlights how these laws have resulted in the taking away of people's liberties. Furthermore, under current legislation, nurses in New Zealand have become the frontline enforcers of the law, a situation in direct conflict with their role of therapeutic agent. It is argued that the role of officer of the law is a function that should not come under the purview of health professionals, particularly since those laws are more about public safety than patient care, and the fact that most Duly Authorised Officers are nurses is a step too far away for the therapeutic role.

ACKNOWLEDGEMENTS

Firstly enormous thanks to my supervisor, Shona Thompson, whose feedback during the writing of this thesis has been of incredible value. Also to Alasdair Williamson, associate supervisor, for his understanding of the issues surrounding mental health legislation and the difficulty of what to omit. Credit must also be given to Elaine Papps, who was the first person to stimulate my interest in the discourse analysis method of research.

Huge amounts of kudos and love to my wife, June, who has gone without holidays etc over the past four years, and has been subjected to most weekends of isolation while my home computer has seen more of me than she has.

Thirdly, to UCOL's acquisition librarian, Marian Manning, for her help tracking down documents in the early stages of writing.

Lastly, my thanks to my immediate line-manager, Adrianna Grogan, for her support and encouragement.

“They called me mad, and I called them mad, and damn them, they outvoted me.”

Nathaniel Lee (1653-92), playwright and inmate of Bedlam

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CHAPTER 1: INTRODUCTION

The aim of this thesis is to conduct a discourse analysis of mental health legislation in New Zealand from 1846 to date. The rationale for this timeframe ensues from the fact that the first legislation that dealt with the mentally ill in New Zealand dates from 1846 (Lunatics Ordinance), whilst the law continues to evolve, with the latest changes taking place in 2008 (Mental Health (Compulsory Assessment and Treatment) Amendment Act 2008).

In the early days of colonisation in New Zealand no provision was made for the mentally ill. If there was no family to assist, such people were placed in gaol. As noted by Williams (1987, p.3)

..... madness usually presented as a law and order problem. The first officially recorded case of insanity took place in 1841, and soon after 'pauper lunatics' were housed in 'special premises attached to the Wellington Jail and Auckland Hospital'.

The enactment of the Lunatics Ordinance 1846 aimed to "provide safe custody and the prevention of offences by persons dangerously insane and for the care and maintenance of persons of unsound mind" (Ernst, 1991, p.68; Lunatics Ordinance, 1846).

Since 1846 there has been a series of legislation enacted in New Zealand that deal with mental health issues and the ensuing desire for public safety and compulsory incarceration of those that suffer from mental health problems and are a danger either to themselves or others. Alongside this legislation there has also been a growth of psychiatric power and quite marked changes in the clinical treatment of people with mental health problems (Shorter, 1997). Furthermore societal attitudes to mental illness have also changed over the same time period. The main purpose of this research is to trace those changes and to analyse what they mean in regard to how mental illness or disorder is defined.

Since the 1980s there has been quite vocal emphasis on the recovery model of psychiatric care (Ramon, Healy & Renouf, 2007). It has to be understood that this particular model was

consumer driven (that is people who had experienced psychiatric services), and did not, in fact, originate from mental health services. The professional literature, starting with the psychiatric rehabilitation movement in particular, began to incorporate the concept from the early 1990s in the United States, followed by New Zealand and more recently across nearly all countries within the First World (O'Hagan, 2004). Similar approaches developed around the same time, without necessarily using the term recovery, in Italy, the Netherlands and the UK.

Developments were fuelled by a number of long term outcome studies of people defined as having major mental illnesses in populations from virtually every continent, including landmark crossnational studies by the World Health Organization from the 1970s and 1990s, showing unexpectedly high rates of complete or partial recovery, with exact statistics varying by region and the criteria used (World Health Organisation, 2001).

The cumulative impact of personal stories or testimony of recovery has also been a powerful force behind the development of recovery approaches and policies. A key issue became how service consumers could maintain the ownership and authenticity of recovery concepts while also supporting them in professional policy and practice. Thus, within psychiatry as a whole there has been a shift of power away from psychiatrists and lunatic attendants. Yet, how much of that power shift is obvious in the legislative procedures that pertain to mental health? Despite the fact that the current legislation contains specific sections that give the 'sectioned' patient extra rights to those accorded by the Health and Disability Act 2000, the whole concept of formal or compulsory psychiatric treatment implies that society continues to sanction the power of psychiatrists to ascertain what is acceptable behaviour and what is not.

An example of this concerns homosexuality. It was not long ago that male homosexuality in particular was viewed as a mental disorder (somewhat after the view that it was legislated a

criminal behaviour) (Dynes, 1990). Nowadays homosexuality is no longer included in western diagnostic criteria for mental disorder. Similarly, there has been a shift in societal views about the use of psychoactive drugs, from crime to illness (alcoholism, cocaineism etc), and then, for some writers, to a natural behaviour of human beings from time immemorial, with at least one (McKenna, 1992) coming to the conclusion that human evolution would not have occurred the way it has had it not been for very early man's accidental ingestion of hallucinogenic drugs. Another example of how things have changed over the course of about a hundred years is that, in the nineteenth century, imbecility, a diagnosis that would have resulted in incarceration, included conditions such as epilepsy and learning difficulties, both of which are specifically excluded in present day legislation.

Considering this background a discourse analysis of New Zealand mental health legislation from the earliest days should therefore reflect developments in treatment, changes in societal attitudes and even changes in political stances to some extent.

Since psychiatric nurses are the agents of psychiatric power, in that they enforce compulsory incarceration of patients who are defined by the legislation as requiring it, this research should be of interest to them. Furthermore, since incarceration for the purposes of compulsory treatment by its very nature implies a breach of human rights, any citizen of a democracy should have an interest in the subject. Since New Zealand has a democratic status, the issue is therefore of interest to all its citizens.

This study came about because of the nomenclature of the various enactments that New Zealand has adopted since the signing of the Treaty of Waitangi in 1840. In the early days such legislation inevitably referred to 'lunatics' and 'lunacy', a clear reference to pathological conditions, even though the theoretical basis for such terms was based on a false premise, that of the influence of the moon on mental stability. Latterly legislation refers to 'mental health', a

term that implies normality. How then did this change in nomenclature arise? Does the change reflect better outcomes in the treatment of mental illness, or is it merely a reflection of today's political correctness, whereby supposedly prejudicial terminology is replaced with words that do not reflect the true intention of the law but merely substitutes euphemisms?

In order to attempt an answer to these questions, this work is organised in the following fashion:

Chapter 2 explains the methodology of discourse analysis.

Before any analysis of New Zealand legislation can take place, its historical background must be understood. Consequently the development of mental health legislation in the United Kingdom from its medieval period until the adoption of the English legal system in New Zealand is discussed in Chapter 3. This is sub-divided into seven sections, the first of which is an introduction. The remainder of these subsections discuss the various types of legislation in the following order: De Prerogativa Regis, the Act of Supremacy, the Witchcraft Acts, the Poor Law Acts, the Vagrancy Acts, and lastly, the various Madhouses and Asylums Acts.

The historical development of mental health legislation in New Zealand is discussed in Chapter 4, which is also sub-divided into sections. Again, the first of these is an introduction to the subject. The remaining three sub-sections discuss the Lunatics Acts, the Mental Defectives Acts, and the Mental Health Acts respectively.

Findings from the actual analysis of the various laws are to be found in Chapter 5, again with sub-divisions. These are an introduction; an exploration of the definition of 'lunacy', entitled Lunacy Defined; a similar exploration of the definition of 'mental defective'; an exploration of the legal definitions of mental disorder from the Mental Health Acts; a discussion of the exemptions from the current definition under the Mental Health (Compulsory Assessment and

Treatment) Act 1993; an examination of the 'rights' that the same current legislation 'bestows' upon those who become subject to it; and lastly a discussion over the concept of danger, which underlies all the mental health legislation New Zealand has enacted.

The final chapter, Chapter 6, concerns the concluding remarks, and the implications of the findings for nurses.

CHAPTER 2: METHODOLOGY

Discourse has been defined as “a belief, practice or knowledge that constructs reality and provides a shared way of understanding the world” (McCloskey, 2008, p.24). Language, therefore, can construct how we perceive ourselves, our lived experiences, and how we interact with others, all of which are important ideas within the field of nursing. From the field of critical social theory, which is underpinned by the philosophy that social phenomena must be understood within terms of their context and history, there is a presupposition that all language is social and that social structures and interactions produce and sustain discourse. Critical social theory also emphasizes that discourse produces, resists and supports power, domination and social inequities (Van Dijk, 1997) all of which are relevant to the study of legislation concerning the mentally ill. The discourses of those pieces of legislation under study, therefore, must have had some influence on how nurses have worked with the mentally ill in New Zealand.

The philosophical standpoint that underlies the practice of discourse analysis can be said to be structuralist and post-structuralist in nature. Structuralism rejects the notion of an absolute truth, but takes the view that cultural and social contexts form the truth. Post-structuralism goes further and emphasises how language is constructed around a particular phenomenon or concept with the aim of making it ‘knowable’ or a certainty. This is particularly relevant concept with regard to this thesis, as the language that is used in the relevant legislation would fall into that category.

Discourse analysis (DA) is a general term for a number of approaches to analyzing written, spoken or signed language use, focussing on the meaning of the language used rather than its linguistic organisation (Smith & Bell, 2007). It is difficult to give a single definition of

discourse analysis as a research method, in that it is neither a qualitative nor a quantitative research method (although some authors insist that it is a qualitative method (Fulcher, 2005)), but a manner of questioning the basic assumptions of quantitative and qualitative research methods.

A discourse is a particular theme in the text, especially those that relate to identities. Discourse analysis is a way of understanding social interactions (Slembrouck, 2006). The term itself first came into general use following the publication of a series of papers by the renowned American linguist Zellig Harris (October 23, 1909 - May 22, 1992) beginning in 1952 and reporting on work from which he developed transformational grammar in the late 1930s (Given, 2008).

Discourse analysis is nothing more than a deconstructive reading and interpretation of a problem or text, while keeping in mind that postmodern theories conceive of every interpretation of reality and, therefore, of reality itself as a text. The contribution of postmodern discourse analysis is the application of critical thought to social situations and the unveiling of hidden (or not so hidden) politics within the socially dominant as well as all other discourses (interpretations of the world, belief systems, etc.) (Gee, 2005; Slembrouck, 2006).

Discourse analysis can be applied to any text, that is, to any problem or situation. It involves reading and analysing texts for their social and political significance, and thus challenges to prevailing practices within the area of study can be made (Gee, 2005; McCloskey, 2008). Since discourse analysis is basically an interpretative and deconstructing reading, there are no specific guidelines to follow (Slembrouck, 2006). Discourse analysis remains a matter of interpretation. As there is no hard data provided through discourse analysis, the reliability and the validity of research/findings depends on the force and logic of arguments made within the analysis. Even the best constructed arguments are subject to their own deconstructive reading

and counter-interpretations. The validity of discourse analysis is, therefore, dependent on the quality of the rhetoric. Despite this fact, well-founded arguments remain authoritative over time and have concrete applications. Discourse analysis is applicable to every situation and every subject. No technology or funds are necessary and authoritative discourse analysis can lead to fundamental changes in the practices of an institution, a profession, and society as a whole (Slembrouck, 2006). However, it does not provide definite answers; it is not a 'hard' science, but an insight based on continuous debate and argumentation (Slembrouck, 2006).

Using a discourse analysis as a research design affords a number of ways of analysing data. In this project, the legislation will be analysed using a genealogical discourse analysis approach, based on the work of Michael Foucault, the 20th century French philosopher, whose work in the area of discourse analysis has been immensely influential (Given, 2008; Stevenson, 2004). The postmodernist approach that he developed (although he himself would have denied any particular philosophical stance) presumes that there are multiple truths and perspectives behind 'reality' (Kelly, 2009b). Central to Foucault's ideas about reality is the notion that discourse has a direct relationship with knowledge and power (Given, 2008; Stevenson, 2004). Power permeates every aspect of society, is inextricably linked with knowledge and creates its own truth. Discourse itself can be variously interpreted as meaning speech or text, but Foucault maintained that there was more to discourse than mere words and that any discourse can be situated within broader societal parameters (Slembrouck, 2006). Thus discourse analysis can expose how everyday experiences are socially constructed, and how societal power, domination and subordination shape those experiences (Given, 2008; McCloskey, 2008; Stevenson, 2004). Those in positions of power create discourses that have the potential to control the thinking and actions of others. This has certainly been true within the context of psychiatry, where the power of doctors has gained in strength over the last three centuries, with an associated increase in the number of syndromes that fall within the bounds of psychiatry.

Genealogical analysis attempts to place within historical and political contexts the development of society's rules and norms (Slembrouck, 2006). This is the most appropriate form of discourse analysis with regard to the chosen research topic, as it tries to explain the history of the present, or how history has evolved to give us present day phenomena. History in this context does not necessarily mean events that occurred in the distant past, but rather anything of relevance that precedes the current analysis. There is not an emphasis on how the present emerged out of the past, but history is used in this context as a means of diagnosing the present (Kendall & Wickham, 1999). Thus genealogical analysis looks at the changing terminology within an area of study and how this relates to power. Clearly this is relevant when one considers the apparent change from the early days of New Zealand psychiatric legislation, which talked about lunacy (a disordered state), to that of the present day, which appears to assume that mental health, a state of normality, surely, requires compulsory treatment and assessment. How did the language of the legislation contribute to the development of the psychiatric professions, the division of the sane from the insane, and the procedures associated with the care of the mad? This is paramount importance today, with nurses being in the frontline of such care.

During the very early stages of writing this thesis, the following databases were searched for relevant literature: Science Direct, PubMed, ProQuest, Academic Search Premier, Biomedical Reference Collection Basic, CINAHL Plus with Full Text, Health Source Nursing/Academic Edition, MasterFile Elite, MasterFile Premier, Medline, Psychology and Behavioral Sciences Collection, and Google Scholar. Searches were conducted for literature that included the terms 'mental health law' and 'discourse' and numerous possible synonyms for each term. None of these databases gave any results for the relevant terms. A general Internet search was then carried out through Google search engine. This again, proved of no value, since there were no specific results. It appears that discourse analysis of mental health legislation has not been

conducted at all, let alone within New Zealand. The fact that such analysis appears not to have taken place could be viewed as a good thing in that the choice of this subject could open up a whole new area of research for nurses. There is a great deal of literature about discourse analysis, both from a theoretical point of view, and also from the basis of nursing research (for example: Campbell & Arnold, 2004; Crowe, 2004; Harper, 1995; Hui & Stickley, 2007; Johnstone, 2008; Jorgensen & Phillips, 2002; Obeng & Hartford, 2008; Paterson, 2007; Powers, 2007; Rudge & Morse, 2001; Salkie, 1995; Schiffrin, Tannen & Hamilton, 2001; Smith, 2006; Widdowson, 2004), all of which were read in the early part of producing this thesis. However, none of these sources relate to the theme in hand.

2.1. METHOD

For the purposes of this discourse analysis, all documents specifically pertaining to legislation concerning mental health issues in New Zealand were collected from various sources. The most recent Acts are available from the New Zealand Government's website (<http://www.legislation.govt.nz>). Some of the older Acts are available from another New Zealand website (<http://legislation.knowledge-basket.co.nz>). All of the early Acts were collected from the pertinent compilations of New Zealand legislation known as *Statutes of New Zealand*, which were published in either Auckland or Wellington, depending on date of publication. By means of these methods of collecting the documents, a total of thirty-four laws were analysed. These are listed in Appendix A.

CHAPTER 3: THE HISTORICAL CONTEXT

3.1: INTRODUCTION

Before any analysis of the pertinent laws of New Zealand can take place, the historical foundation of mental health law within the Anglo-Saxon legal system needs to be examined. The legal system in New Zealand is based on the British system, and from that system came several laws that shaped the fledgling colony's legal attitude to dealing with the insane. This chapter will examine those laws.

Mental health problems are probably as old as humanity itself. It is believed, for example, that the existence of trepanation (from the Greek *trypanon*, meaning drill (Kelly, 2009a)) holes in Neolithic skulls may have been an attempt at prehistoric psychosurgery to relieve the symptoms of mental illness (Arnott, Finger & Smith 2003; Brothwell, 1963; Hinshaw, 2007; Kelly, 2009a; Mariani-Costantini, Catalano, di Gennaro, di Tota & Angeletti, 2000; Mashour, Walker & Martuza, 2005; McClennon, 1997; Millon, 2004; Misios, 2007; Mo, 2007; Porter, 2002; Sabbatini, 1997; Selling, 1940; Thackery & Harris, 2003). Such skulls have been found all over the world (Blos, 2003; Kelly, 2009a). The smoothness and shininess of the bone around the trepanned holes is evidence that the patients not only survived the operation, but lived on for months or years while the bone regrew, with a survival rate of around 75% (Lillie, 1998; Thackery & Harris, 2003). However, there is no evidence to suggest that there was a medical philosophy, as there was little difference between medicine, magic and religion (Darton, 1999; Millon, 2004; Rao, 1978). Trepanation as a treatment in mental illness continued up to the nineteenth century (Tuke, 1892).

Madness was an early synonym for disturbances of mind, first appearing in the English language in the 1300s (Elder, Evans & Nizette, 2005). The problem with this early diagnostic label was that it did not differentiate between true mental illness and other disorders, such as

intellectual handicap, neurological disorders such as epilepsy, and other conditions that gave rise to disturbances in thought, emotion or behaviour (Thackery & Harris, 2003). Madness is not the only terminology that the English language has developed to describe disorders of the mind. Urdang and LaRoche (1978) list 139 synonyms for madness, and 63 synonyms for madman. These do not include many of the slang terms that have become associated with madness, expressions such as ‘bats in the belfry’, ‘two sandwiches short of a picnic’ and so forth. DeFalco (2005) gives a good explanation as to the sources of many of the synonyms of madness, as does Conolly (1850).

One of the earliest terms used to describe disorders of the mind was ‘lunacy’, based on the notion that the phases of the moon affected mental stability. This term is particularly relevant to this study as the earliest mental health legislation in New Zealand uses the term ‘lunatic’ for those who became subject to it. Hippocrates, who lived in the era of c. 460 B.C.E. to c. 370 B.C.E., and who has been called the “father of medicine” (Byers, 1998; Keyser & Irby-Massey, 2008), appears to be one of the first writers to mention the harmful effect of the moon on mental stability (Porter, n.d.), a notion that still exists at a popular level (Simpson & Roud, 2000).

Today mental and behavioural disorders are estimated to account for 12% of the global burden of disease (World Health Organization, 2001), with a prediction that it will rise to 15% by 2020. Mental disorders also represent four of the ten leading causes of disability worldwide. Despite these figures it is also estimated that the mental health budgets of the majority of countries constitute less than one percent of total health spending (World Health Organization, 2001). From the same report, it is stated that more than 40% of countries have no mental health policy and over 30% have no mental health programme. Furthermore, over 90% of countries have no mental health policy that includes children and adolescents. These figures are extremely worrying when one considers that over 25% of all people experience mental disorders at some

time in their lives. In 2000 this gave rise to an estimated number of 450 million people worldwide suffering from neuropsychiatric conditions (World Health Organization, 2001). Treatment for these disorders is not a universal constant, and human rights abuses still occur, with the WHO report stating that, in 1999 and 2000, of all the hospitals visited by the Human Rights Commission worldwide, under a quarter were staffed by trained psychiatric nurses. Furthermore, at least one third of patients were without psychiatric diagnoses that warranted their being in the hospital in the first place. Of 160 countries that supplied information on their mental health services for the purposes of the report, nearly a quarter had no mental health legislation, and, of those that did have such legislation, nearly 20% reported that their legislation dated back over forty years (World Health Organization, 2001). Legislation in many countries is therefore outdated.

Fortunately, New Zealand does not fall into this category as it has a history of mental health legislation that dates from just after the establishment of New Zealand as an entity under the Treaty of Waitangi. However, the World Health Organization also identifies that much of the outdated legislation breaches human rights rather than protects them (World Health Organization, 2005). This statement seems a little odd, in that most countries that do have mental health legislation have the idea of compulsory assessment and treatment for mental health problems, and this in itself has to be considered a breach of human rights, especially since *perceived* danger is almost universally the major criterion for such an admission to take place. Note the emphasis here is on perceived danger rather than actual.

3.2: DE PREROGATIVA REGIS

Whilst mental illness has been associated with the species *Homo sapiens* since prehistoric times, legislation associated with it is a fairly recent event. Within the English legal system the

earliest codified reference is in a 1324 statute known as *De Prerogativa Regis* (Andrews, Briggs, Porter, Tucker & Waddington, 1997; Baly, 1995; Fry, 1864; McGlynn, 2003; McGlynn, 2005; Tuke, 1892; Wallace & Gach, 2008; Williams, 1816; Winslow, 1898; Wright & Digby, 1996). This gave jurisdiction over the persons and property of “idiots” and those who “happen to fail their wit” (that is, those who were deemed incapable of looking after their own affairs) to the monarch (Bartlett & Sandland, 2007; Letchworth, 1889; Winslow, 1898; Wright & Digby, 1996). The king was to hold the lands of the idiot without committing waste, to provide for the idiot from the lands so held, and to return the lands to the idiot’s family on the death of the idiot (McGlynn, 2005; Williams, 1816). In the case of lunatics, should they recover their senses they would have to prove to chancery that they were no longer mad in order to reclaim their property (McGlynn, 2005). The primary purpose of this law was to ensure that people with mental health difficulties were not exploited (Ramsay, Szmukler, Gerada & Mars, 2001). The officers who enforced this legislation throughout the realm were known as ‘escheators’ (McGlynn, 2003), who held inquisitions to determine whether or not the landowners concerned were lunatics or idiots (Roberts, 1981a). Roberts (1981a) cites two examples of this Act in operation from the year 1464.

This legislation did not, however, have any bearing on the treatment of mental disorders, nor where such treatment should take place. In fact, the only public institution for the mentally disordered for several centuries (until 1724, when the Norfolk asylum was founded (Shorter, 2005)) was Bedlam, formerly the Priory of St Mary of Bethlehem at Bishopgate, London, founded in 1247 (Allderidge, n.d.; Andrews, Briggs, Porter, Tucker & Waddington, 1997; Andrews & Scull, 2003; Porter, 1997; Shorter, 2005; Walsh, 1907; White, 2006) by Simon Fitz Mary, an Alderman and Sheriff of London. By 1329 it had begun to be called a hospital (Noll, 2007), in the sense that patients were admitted to be cured, but those who did not recover might stay for years. In 1346 Bedlam came under the patronage and protection of Richard Lacer,

mayor of London, and the citizens of London (Andrews, Briggs, Porter, Tucker & Waddington, 1997). This was said to have brought to an end a century of disaster, poverty, and failure (Street, 1994). The hospital began to receive “lunatics” in 1377 (Evans, 1977). A visit by commissioners of Henry IV in 1403 made mention of “men deprived of reason” (Allderidge, n.d.; Clay, 1906; Jay, 2003) and noted that there were nine inmates (Andrews, Briggs, Porter, Tucker & Waddington, 1997; British Broadcasting Corporation, 2004). An inventory of hospital equipment from this time lists 4 pair of manacles, 11 chains of irons, 6 locks and keys and 2 stocks (Andrews, Briggs, Porter, Tucker & Waddington, 1997; Pacht, 1996), which gives some idea of the form of treatment that was current. It could be argued that the asylum form of incarceration of the mad, imported to New Zealand from the United Kingdom in the 19th century, started with Bedlam. As Finane (2003, p. 86) points out:

The asylum as a Victorian institution suffered from its enduring association with the madhouse of Bedlam, with the uncontrollable behaviours of its inmates, perpetrators but more often victims of abuse and violence.

3.3: ACT OF SUPREMACY

The schism between the English monarch and the Roman Catholic Church that resulted in Henry VIII becoming head of the Church of England in 1534, (Act of Supremacy 1534) (Newcombe, 1995; Tittler & Jones, 2004), has a bearing on later legislation impinging on the lives of the mad. Since there was a shift from Catholicism to Protestantism, there ensued the concept of the Protestant work ethic (Hill, 1996). The French theologian Calvin taught that all men must work, as it was God’s will (Hill, 1996), and thus Protestantism enshrined the idea that work was a religious duty. This notion became a legal prerequisite with the introduction of the Poor Law Acts, discussed further below. Idleness was no longer to be tolerated (Szasz, 1994), and the people were to be forced into work if they had not voluntarily taken on the religious duty. Since the mad had not had any previous compulsion to work, they became some of the

targets of the new legislation. All of the charities that had been operated by the Roman Catholic church (including those that had dealings with the mad) ceased operation in the 1530s (McIntosh, 2005). Prior to this time, roughly 7-8 per cent of monastic income had been devoted to poor relief, which would have included funds to care for the mad (Tittler & Jones, 2004).

3.4: WITCHCRAFT ACTS

The next pieces of English legislation that came into being that had direct effect on those who were suffering mental health problems were a series of Witchcraft Acts passed between 1541 and 1735, the last of which banned the practice of judicial murder of those condemned as witches (Adams, 1889; Buckland, 1986; Burns, 2003; Dock, 1920; Gaskill, 2000; Golden, 2006; Guiley, 2008; Jones, 1972; Pugh, 2001; Williams, 1865) and suggested that claims of witchcraft were fraudulent. It was not until 1951 that the last Witchcraft Act was repealed (Buckland, 1986; Guiley, 2008; Levack, 2004). The last execution of a convicted “witch” was in 1782 (Golden, 2006; Millon, 2004), and the last known trial for witchcraft took place in Poland in 1793 (Nemec, 1974). The last execution of a witch in Britain was in 1727 in Scotland (Guiley, 2008; Levack, 2004; Pugh, 2001; Tuke, 1882).

The spread of Christianity throughout Europe in the Middle Ages had resulted in a somewhat catastrophic purge of the insane under the guise of faith – the witch hunts, or ‘Burning Times’ as modern Wiccans call the phenomenon (Guiley, 2008; Lewis, 1999), the term having been coined by the 20th century Wiccan leader, Gerald Gardner (Golden, 2006; Simpson & Roud, 2000). According to Millon (2004) and others (Burns, 2003; Mackay, 2009), medieval Christian mythology included a belief that there was a worldwide Satanic conspiracy to destroy Christianity (Bonewits, 2001; Carus, 1900; Mackay, 1841), and that the agents of this conspiracy were witches, who not only worshipped Satan (Burns, 2003; Gurses, 1997), but also engaged in other heinous activities including murder, cannibalism and sexual orgies (the anxiety

over the latter being provoked by the sexual activities of some monks and nuns (Darton, 1999)).

As a result of this misguided belief, the Inquisition (the Holy Office of the Inquisition of the Roman Catholic Church, established in 1188 by Pope Lucius III, to prevent the spread of heretical movements (Lewis, 1999; Nemeč, 1974)) was informed in 1233 by Pope Gregory IX to root out witches, heretics and all other agents of the Evil One (Bailey, 2003a; Guiley, 2008; McBrien, 2006; Porter, 2002). Images of witches riding broomsticks first appeared in 1280 (Ellerbe, 1995). Pope Paul II, in 1468, declared witchcraft a “*crimen exceptum*” (Golden, 2006), thus giving ecclesiastical and secular courts complete freedom in dealing with witches (Nemeč, 1974). Not only the leaders of Christianity believed this, but it was also taken on by the common people, and it was a belief still prevalent in the 17th century.

The Old Testament was often quoted as a rationalisation for these beliefs, particularly Exodus xii, 18: “Thou shalt suffer no witch to live”. Zimmermann & Gleason (2000) opine that this passage was originally worded “Thou shalt not suffer a poisoner to live,” but that King James I, whose translation of the Bible is the commonly accepted version, was so fearful of witches that he changed the wording to that given here. This is reinforced by Bonewits (2001), Burns (2003), and Golden (2006). King James also wrote about witchcraft himself, publishing *Daemonologie* in 1597 (Burns, 2003; Guiley, 2008; James VI, 1597).

Both Catholics and Protestants believed that witches could invoke demons to possess others (Bailey, 2003b), and it was the duty of the church (in whatever form) to force those who were possessed by demons to admit to being witches and to deliver the names of other witches to the church. This admission was evinced by torture (Bailey, 2003b; Bonewits, 2001, Burns, 2003; Carus, 1900; Shermer, 2002) and, once elicited, the punishment for being guilty was usually death, especially by burning at the stake (although the English Witchcraft Acts of the 16th

century prescribed hanging as the penalty (Burns, 2003; Simpson & Roud, 2000)); it has to be said, however, that the religious leaders who recommended such punishment would not have seen it as such – rather it was seen as a benevolent act that rid the victim of a possessing demon.

It could also be argued that the witchcraft delusion was the church's paternalistic means of disempowering women (Al-Sharif, 2004; Burns, 2003; Ellerbe, 1995; Golden, 2006; Herzig, 2006; Jackson, 1995; Schuler, n.d.; Toivo, 2005), as more women than men were accused of being witches (between 75 and 90 percent of those convicted were female, depending on place and time (Bailey, 2003a; Bailey, 2003b; Ellerbe, 1995; Stearne, 1648)), while it was argued that more men than women were bewitched, a situation that implies female power, anathema to the church. English witches in particular were often elderly women (Ellerbe, 1995; Fletcher, 1896) who depended on others for charity, and the thinking was that they were resentful of those who refused them such charity (Simpson & Roud, 2000), leading them to utter curses and other magical incantations (Gaskill, 2000).

In 1484 Pope Innocent VIII, in his bull *Summis Desiderentes Affectibus*, spoke out against witchcraft and exhorted the church to stamp the practice out, by whatever means necessary (Bailey, 2003b; Buckland, 1986; Campbell, 1986; Carus, 1900; Darton, 1999; Ellerbe, 1995; Flinn, 2007; Fulford, Thornton & Graham, 2006; Golden, 2006; Green, 1997; Guiley, 2008; Gurses, 1997; Harrison, 1975; Hinshaw, 2007; Levack, 2004; Mackay, 2009; Maxwell-Stuart, 2001; Millon, 2004; Nemeč, 1974; Summers, 1926; Tuke, 1892; Vandermeersch, 1991; Wallace & Gach, 2008; Williams, 1865; Zimmermann & Gleason, 2000). As a result two Dominican friars (the sect of monks that had come to administer the Inquisition (Bailey, 2003b; Carus, 1900; Golden, 2006; Lewis, 1999; Mackay, 2009; Shermer, 2002)), Johann Sprenger (1436-95) and Heinrich Kraemer (c.1430-1505) published *Malleus Maleficarum* (*The Witches' Hammer*), a manual on the detection of witchcraft, the examination of witches and the legal sentencing of

them, first published in 1486 (Bailey, 2003a; Bailey, 2003b; Bonewits, 2001; Buckland, 1986; Burns, 2003; Carson & Cerrito, 2003; Colp, 2000; Darton, 1999; Ellerbe, 1995; Fulford, Thornton & Graham, 2006; Golden, 2006; Green, 1997; Guiley, 2008; Gurses, 1997; Harrison, 1975; Hinshaw, 2007; Hoyt, 1989; Kamen, 2000; Levack, 2004; Mackay, 1841; Mackay, 2009; Maxwell-Stuart, 2001; Millon, 2004; Nemeč, 1974; Pugh, 2001; Vandermeersch, 1991; Wallace & Gach, 2008; Williams, 1865; Zimmermann & Gleason, 2000).

Examination of a person accused of witchcraft included a search for ‘devil’s stigmata’, insensitive marks on the skin, such as red spots, ulcers, or depressions, which were considered proof of having had sexual relations with the Devil (Bailey, 2003b; Burns, 2003; Darton, 1999; Ellerbe, 1995; Fletcher, 1896; Golden, 2006; Guiley, 2008; Jones, 1972; Nemeč, 1974; Notestein, 1911; Pugh, 2001; Summers, 1926; Williams, 1865). In England the most notorious witch finder was Matthew Hopkins, who proclaimed himself the ‘Witchfinder-General’ and travelled throughout the land, arranging executions of witches, particularly in East Anglia (Burns, 2003; Carus, 1900; Kamen, 2000; Mackay, 1841; Simpson & Roud, 2000) in 1645-6, resulting in the loss of over 200 lives (Bailey, 2003b; Guiley, 2008). Hopkins died in 1647, probably from tuberculosis (Stearne, 1648), but legend has it that he was accused of witchcraft himself and was hanged (Burns, 2003; Guiley, 2008; Kamen, 2000; Simpson & Roud, 2000).

The *Malleus Maleficarum* served the Inquisition well and resulted in perhaps hundreds of thousands of innocent men and women put to death at the stake, or, in Britain, by hanging (Gaskill, 2000; Golden, 2006; Guiley, 2008; Hills, 1901; Lewis, 1999; Millon, 2004; Regis, 1894). Pet cats were often killed at the same time as their owner, as the belief was that the feline was a familiar who helped the witch in her evildoing (Bailey, 2003b; Burns, 2003; Ellerbe, 1995; Fletcher, 1896; Golden, 2006), although this practice appears to have been more prevalent on the mainland of Europe than the British Isles (Simpson & Roud, 2000). Many of the

prosecutions for witchcraft ensued from personal feuds (Burns, 2003; Gaskill, 2000). Of the successful prosecutions, many would have been of people with mental health problems (as mental illness was seen as being due to possession by demons) – easy prey to accusations of crop-spoiling, causing illness, shape-changing, controlling the weather, the ‘evil eye’ and so forth (Bailey, 2003b; Burns, 2003; Guiley, 2008; Hills, 1901; Notestein, 1911), the sort of behaviours that witches were supposed to demonstrate. This is borne out by at least one writer of the time, Pierre Pigray of France who commented on an examination of fourteen people in 1589 in Paris:

We found them to be very poor, stupid people, and some of them insane; many of them were quite indifferent about life, and one or two of them desired death as a relief for their sufferings. Our opinion was, that they stood more in need of medicine than of punishment, and so we reported to the Parliament. Their case was, thereupon, taken into further consideration, and the Parliament, after mature counsel amongst all the members, ordered the poor creatures to be sent to their homes, without inflicting any punishment upon them.

(Mackay, 1841, p. 237).

Not everyone agreed with the purge. For example, in 1460, Dominican monk and professor of logic at the University of Milan, Girolamo Visconti (Golden, 2006), admitted in his book on witchcraft that “many men of learning and authority think that these [witches’] illusions arise from a melancholic humor, depriving women of reason and free will.” (Nemec, 1974, p.5).

The Dutch physician Johann Weyer (1515-88) also wrote against the persecutions (Bailey, 2003b; Burns, 2003; Carus, 1900; Colp, 2000; Darton, 1999; Golden, 2006; Guiley, 2008; Maxwell-Stuart, 2001; Oldridge, 2005; Porter, 2002; Millon, 2004; Slattery, 1994; Vandermeersch, 1991; Wallace & Gach, 2008; Williams, 1865) in his *De Praestigiis Daemonum et Incantationibus ac Venificiis* (On the Illusions of the Demons and on Spells and Poisons), published in 1563. (Sigmund Freud ranked this book among the ten most important he had read (Golden, 2006)). Weyer believed that melancholy (insanity) caused many delusions

and hysterical 'imaginings', and that 'magicians' and 'diabolists' were actually the victims of hysteria or hypochondriasis (Burns, 2003; Golden, 2006; Kamen, 2000; Levack, 2004; Nemas, 1974; Oldridge, 2005). He also stated that "Witches' experiences are delirious dreams induced by drugs." This is pertinent when one considers the so-called flying ointments of witches. These included extracts from various hallucinogenic plants (Lewis, 1999), including aconite, belladonna, hemlock, henbane, wormwood, and mandrake (Bever, 2008; Golden, 2006; Guiley, 2008; Harrison, 1975; Hoyt, 1989; Simpson & Roud, 2000; Summers, 1926). Furthermore, the ointment was said to have been applied to broom handles (Bailey, 2003b), which were then inserted vaginally such that the active alkaloids present in the ointment were absorbed through the mucous membranes. This practice gave rise to the belief that witches rode broomsticks (Burns, 2003; Golden, 2006; Guiley, 2008; Harrison, 1975; Pollan, 2001). Weyer has also been recognized as the first writer to state that suicide is often a manifestation of despair (Rush, 1988). Because of his antithesis to the witchcraft craze, Weyer's book was proscribed by the Catholic church, and Weyer himself was accused of sorcery (Darton, 1999; James VI, 1597; Wallace & Gach, 2008).

A third author who spoke out against the witch trials was the Englishman Reginald Scot (1538-1599) in his *The Discoverie of Witchcraft*, which was published in 1584 (Bailey, 2003b; Burns, 2003; Golden, 2006; Guiley, 2008; Gurses, 1997; Levack, 2004; Maxwell-Stuart, 2001; Oldridge, 2005; Porter, 2002; Scot, 1584; Simpson & Roud, 2000; Williams, 1865). In it, Scot stated:

Alas, I am sorry and ashamed to see how many die who being said to be bewitched, only seek for magical cures, whom wholesome diet and good medicines would have recovered. . . . These affections tho' they appear in the mind of man, yet are they bred in the body and proceed from the humour which is the very dregs of the blood; nourishing those places from whence proceed fear, cogitations, superstitions, fastings, labours, and such like.

(p.xviii)

Shakespeare used Scot's book as a resource, and James I ordered the book to be burned (Bailey, 2003b; Burns, 2003; Guiley, 2008; Gurses, 1997; James VI, 1597; Kamen, 2000; Oldridge, 2005; Simpson & Roud, 2000).

The American colonies did not react as quickly to witchcraft, and in 1692 a hundred and fifty supposed witches were tried in Salem, Massachusetts, with nineteen hanged (Burns, 2003; Elder, Evans & Nizette, 2005; Golden, 2006; Guiley, 2008; Maxwell-Stuart, 2001). Later authors have theorised that the symptoms displayed by these so-called witches were in fact due to ergotism (Guiley, 2006), that is, hallucinogenic poisoning due to the fungus *Claviceps purpurea* (Barger, 1931; Bonnet & Basson, 2004; Kren & Cvak, 2006; Stafford, 1993).

3.5: POOR LAW

In 1598 another piece of English legislation that had some bearing on the insane was passed. This was the Poor Law Act, which required every parish to appoint overseers of the poor to find work for the unemployed and set up parish-houses for poor people who could not support themselves (Benson, 2007; McIntosh, 2005; Szasz, 1994; Wright, 2000). Obviously, since the insane could easily be numbered among the unemployed, this would have had an effect on their lives (Roberts, 1981a).

A further and not too dissimilar Act was passed in 1601, replacing the 1598 Act. Again, each parish was obliged to provide relief for the aged and the helpless (Aschrott, 1888; Fowle, 1898; Jones, 1972; McIntosh, 2005; Szasz, 1994), to bring up unprotected children in habits of industry, and to provide work for those capable of it but who were lacking their usual trade. The 'impotent poor' (that is, anyone with some form of disability, and this presumably included the mad) could be housed in almshouses or poorhouses. The relief and maintenance of such persons

became the legal responsibility of their parents, grandparents, or children, if such relatives were themselves able to provide such support (Higginbotham, 2009). This Act remained in force until 1834 (Aschrott, 1888; Slack, 1984), and because of this is often referred to as the “old poor law” (Roberts, 1981a; Wright, 2000). It has been described as the administrative foundation on which mental health care was based (Murphy, 2003).

Both of the above-mentioned laws can be said to derive directly from the Protestant Reformation and the advent of the Protestant work ethic, as mentioned previously.

3.6: VAGRANCY ACTS

The 1714 Vagrancy Act is the first piece of British legislation that specifically mentions involuntary incarceration of the mad (Roberts, 1981a; Skultans, 1987):

And whereas there are sometimes in parishes, towns and places, persons of little or no estates, who, by lunacy, or otherwise, are furiously mad, and dangerous to be permitted to go abroad, and by the laws in being, the Justices of Peace and officers have not authority to restrain and confine them; be it therefore enacted by the authority aforesaid, that it shall and may be lawful for any two or more of the Justices of the Peace of any county, town or place in England, Wales or Town of Berwick upon Tweed, where such lunatic or mad person shall be found, by warrant under their hands and seals, directed to the constables, church-wardens, and overseers of the poor of such parish, town or place, or some of them, to cause such person to be apprehended...

(Roberts, 1981b, para. 46)

However, it has been argued that this law was in fact based on common law (Blackstone, 1768).

It was the first piece of British legislation that made separate reference to the mad (Gregory, 1987). Again, it can be said to derive from the Protestant Reformation when seen as a further extension of the work ethic.

As far as criminal responsibility and madness was concerned, by the end of the Middle Ages British legal culture had accepted the idea that:

an act is not legally cognizable as evil, and hence criminally punishable, unless it is committed by a person who has the capacity to cognize the act as evil, and then freely chooses to do it.

(Golding & Roesch, 1987, pg. 378.)

This principle was formulated in 1724 by Justice Tracy in what has become known as ‘the wild beast rule’ (Argent, 1978; Noll, 2007; Slovenko, 1995), whereby a person cannot be found guilty if they are “totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, a brute, or a wild beast” (Cobbett, 1816, vol. XVI, p. 765; Moore, 1984, p. 66). The defendant, one Edward ‘Ned’ Arnold, had shot and wounded Lord Thomas Onslow. Witnesses avowed that he had been mad since a child, citing an incident where he had tossed red hot coals on to his father’s dinner plate, and others where he had hooted like an owl or shouted “Cuckoo!” The reason he gave for shooting Lord Onslow was that he had been filling him with bugs, plagues, “bollies and bolleroyes”. Despite this, the jury were not satisfied that Arnold showed insufficient understanding to be counted as a wild beast, so found him guilty and recommended capital punishment. Arnold’s life was only spared when Onslow himself asked for mercy to be shown (Slovenko, 1995). Arnold spent the rest of his life in prison. Because witnesses were called, this case has been seen as paving the way for medical testimony in later cases, and the most commonly cited as the beginning of the insanity defence (Freedheim & Weiner, 2003).

The Vagrancy Act of 1714 was replaced by the Vagrancy Act of 1744, which defined one class of vagrant as anyone “who by lunacy or otherwise are so far disordered in their senses that they may be dangerous to be permitted to go abroad” (Boyle, 1990, p. 26; Tuke, 1882, p. 98). This resulted from a parliamentary committee which had been set up in 1742 to consider the treatment of rogues and vagabonds (Jones, 1972), something that tended to happen every thirty or forty years throughout the 16th, 17th and 18th centuries. By this time the increase of vagrancy

in England was so much that the Act itself starts with the words “whereas the number of rogues, vagabonds and other idle or disorderly persons daily increases, to the great scandal, loss and annoyance of the kingdom” (Jones, 1972, p. 25). With regard to mental health issues, this Act allowed unregulated confinement of the ‘furiously and dangerously mad’ (Argent, 1978). Any person could apprehend such a dangerous lunatic (and be paid a reward of five shillings for doing so (Jones, 1972; Jones, 2003)), with two Justices of the Peace deciding whether or not it was necessary to detain the said lunatic in a place of safety (Bucknill & Tuke, 1858; Letchworth, 1889; Williams, 1816). At no point does this legislation recognise lunacy as a medical problem, with no medical certification of madness being necessary and no mention of treatment (Jones, 2003), even though it does mention ‘curing’. Instead it focuses on behaviour which may be dangerous to others, with the only form of ‘treatment’ being restraint in chains (Bucknill & Tuke, 1858; Conolly, 1850; Jones, 1972; Williams, 1816). This could be viewed in two different lights: negatively, restraint in chains is not much of a treatment, but positively, at least whippings were not part of treatment for the insane, as it was for other forms of vagrancy (Mackenzie, 1992; Rushton, 1988). The fact that two J.P.s were necessary to deem a person mad, in contrast to any other form of vagrancy (where only one J.P. was necessary) may have been to prevent the abuse of power by a single J.P, who may have been tempted to indulge in personal grudges otherwise (Jones, 2003).

In practice the safe places where such lunatics were held was prison, since no other establishments were yet in existence to prevent escape (Jones, 2003). Incarceration could be for a period of up to a month (Fawcett & Karban, 2005; Jones, 1972). In common with the previous Vagrancy Act, the lunatic was to be removed back to their home parish, such that the cost of keeping them in safe circumstances did not fall on other local authorities (Gregory, 1987; Skultans, 1987; Williams, 1816; Winslow, 1898). The costs for keeping them safe could be taken from any property or money that the lunatic had (Williams, 1816; Winslow, 1898), but

only after the costs of caring for the lunatic's family had been met.

It shall and may be lawful for any two or more Justices of the Peace where such lunatic or mad person shall be found, by warrant under their hands and seals, directed to the constables, churchwardens and overseers of the poor of such parish, town or place, to cause such persons to be apprehended and kept safely locked up in some secure place.....as such justices shall appoint; and (if such justices find it necessary) to be there chained.....The charges of removing, and of keeping, maintaining and curing such persons during such restraint (which shall be for and during such time only as such lunacy or madness shall continue) shall be satisfied and paid.....by order of two or more Justices of the Peace, directing the churchwardens or overseers where any goods, chattels, lands or tenements of such persons shall be, to seize and sell so much of the goods and chattels, or to receive so much of the annual rents of the lands and tenements, as is necessary to pay the same; and to account for what is sold, seized or retrieved at the next Quarter Sessions; or, if such person hath not an estate to pay and satisfy the same, over and above what shall be sufficient to maintain his or her family, then such charges shall be satisfied and paid by the parish, town or place to which such person belongs, by order of two Justices of the Peace directed to the churchwardens or overseers for that purpose.

(Vagrancy Act, 1744; Section 20.)

The only achievement, from a humanitarian point of view, that this Act has is that it is the first time legislation recognised that the mad may need treatment.

3.7: MADHOUSES & ASYLUMS ACTS

The Madhouses Act of 1774 required the Royal College of Physicians to license by committee all madhouses within seven miles radius of London (Gregory, 1987; Mooney & Reinartz, 2009; Skultans, 1987). Outside of the area, the licensing function fell to the local quarter sessions (Baly, 1995; Bucknill & Tuke, 1858; Corfield, 1995; Fry, 1864; Jay, 2003; Jones, 1972; Letchworth, 1889; Mackenzie, 1992; Porter, 2002; Roberts, 1981a; Shelford, 1833; Tuke, 1892), that is, courts that were held in each county and county borough in England and Wales. Licenses would permit holders to maintain a single house for accommodating lunatics, and would have to be renewed each year. All houses were to be inspected at least once per year by the committee or the court officials outside of London, who would also keep a central register of all the confined lunatics in order that people could locate them (Roberts, 1981a). The penalty for 'concealing or confining' more than one insane person without a license was set at £500

(Mackenzie, 1992; Williams, 1816), and every keeper of such a house who took in a patient without an order from a doctor (no one was to be admitted into a licensed house as a lunatic without "an order in writing, under the hand and seal of some physician, surgeon or apothecary that such person is proper to be received into such house or place as a lunatic" (Madhouses Act 1774, section 21)) was liable to a fine of £100. These fines may not seem exorbitant in today's terms, but the fine of £500 is equivalent to over £25000 in today's values, and a fine of £100 in the 1770s would be equivalent to over £5000 today (Robinson, 1997). Although Parliament had decided that the Madhouses Act was only to remain in force for five years, it was in fact continued for a further seven years by the Madhouse Continuation Act of 1779, and then continued indefinitely by the Madhouse Law Perpetuation Act of 1786 (Bucknill & Tuke, 1858). Thus, it only became redundant when it was repealed by the Madhouses Act of 1828 (Roberts, 1981a).

On 15th May 1800 James Hadfield attempted to assassinate George III at Drury Lane Theatre by firing a pistol at him during the playing of the national anthem (Appignanesi, 2008; Argent, 1978; Brooking, Ritter & Thomas, 1992; Highmore, 1822; Ingram, 1991; Jay, 2003; Ray, 1838; Shelford, 1833; Tuke, 1892). His shot missed. Hadfield then said to the king "God bless your royal highness; I like you very well; you are a good fellow" (Highmore, 1822). Hadfield was arrested and his statement at the time was "It is not over yet – there is a great deal more and worse to be done" (Argent, 1978). Later, however, he changed his story and maintained that he had "not attempted to kill the King". Nevertheless, because his intended victim had been the king, Hadfield was put on trial for treason (Argent, 1978; Highmore, 1822; Ray, 1838; Shelford, 1833; Tuke, 1892). He was defended by Thomas Erskine (Appignanesi, 2008; Argent, 1978; Ingram, 1991), deemed to be the best lawyer in England at the time. Erskine succeeded in convincing the judge and jury that Hadfield had only appeared to make an attempt on the King's life in an effort to get himself killed, in accordance with his delusional belief that he must die at

the hands of others (Highmore, 1822; Tuke, 1892). This delusional belief and Hadfield's apparent madness may have been as a result of head injuries (Argent, 1978; Highmore, 1822; Jay, 2003; Shelford, 1833; Tuke, 1892) he sustained at the Battle of Tourcoing (a battle in the French Revolutionary Wars) in 1794. Before being captured by the French, he was struck eight times on the head with a sabre, the wounds being prominent for the rest of his life. (When Hadfield died in 1841 his post-mortem revealed extensive brain damage (Jay, 2003)). These wounds had also resulted in his discharge from the army on the grounds of madness (Argent, 1978; Highmore, 1822; Shelford, 1833). After returning to England, he became involved in a millennialist movement (Jay, 2003; Shelford, 1833) and came to believe that the Second Coming of Jesus Christ would be advanced if he himself were killed by the British government (Argent, 1978). He therefore attempted the assassination of the King, which he hoped would bring about his own judicial execution (Jay, 2003). Hadfield pleaded insanity but the standard of the day for a successful plea was that the defendant must be "totally deprived of his understanding, and memory, and doth not know what he is doing" (Cobbett, 1816, vol. XVI, p. 765). Before 1800, if a defendant was acquitted on the grounds of insanity, he was simply allowed to go free because there was no law in place that allowed the government to detain him (Brooking, Ritter & Thomas, 1992). If the judge presiding over the case thought that it would be dangerous to release the defendant and wanted him detained, a separate civil commitment hearing had to be held before the person could be incarcerated. In some cases, the authorities were able to use the Vagrancy Act of 1744 to confine criminals, but in the majority of cases the defendants were sent home or put into the care of their family.

Hadfield's planning of the shooting appeared to contradict a claim of insanity. Erskine chose to challenge the insanity test, instead contending that delusion unaccompanied by frenzy or raving madness was the true character of insanity (Argent, 1978; Highmore, 1822). Two surgeons and a physician testified that the delusions were the consequence of his earlier head injuries (Argent,

1978). The judge, Lloyd Kenyon, 1st Baron Kenyon, at this point halted the trial declaring that the verdict was clearly an acquittal but "the prisoner, for his own sake, and for the sake of society at large, must not be discharged" (Argent, 1978, p.9). However, according to the Vagrancy Acts of 1714 and 1744, Hadfield could only be held until he had recovered his mind and the concern was that he would be released in a period of lucidity and make another attempt on the King's life at a later date.

Just four days after the trial Hadfield had started (Appignanesi, 2008; Jay, 2003), the prosecution proposed "A Bill for Regulating Trials for High Treason and Misprision of High Treason in certain cases, and for the Safe Custody of Insane Persons Charged with Offenses" (Argent, 1978, p. 15). This bill included both of what was to become the two separate pieces of legislation known as the Criminal Lunatics Act 1800 and Treason Act 1800 (Argent, 1978). The terms of the Criminal Lunatics Act applied to people charged with treason, murder, or felony (Fry, 1864; Highmore, 1822; Shelford, 1833) who were acquitted on the grounds of insanity or who appeared to be insane when apprehended, brought in for arraignment, or summoned for discharge due to a lack of prosecution (Jones, 2003). The procedure for dealing with such people read: "If [the jury] shall find that such person was insane at the time of the committing such offence, the court before whom such trial shall be had, shall order such person to be kept in strict custody, in such place and in such manner as to the court shall seem fit, until His Majesty's pleasure shall be known" (Fry, 1864, p. 553). In essence, the Criminal Lunatics Act required the detention of someone who had committed a crime in a bout of insanity rather than leaving it to the discretion of the judge and jury, even if such detention meant forever. It did not say who was to be declared insane, nor where they should be kept if found so, but subsequent case law determined that those found to be unfit for trial, under the terms of the Act, whether because of deafness, mental defect or madness, became legally "insane", and from this time forward the term insanity has held more of a legal definition than it has in medicine (Grubin,

1996; Tighe, 2005). Argent (1978) makes a good argument that this Act was not merely a law concerning the mad, but that it was rather a panic measure to combat revolution, as had occurred in France just a few years before.

A national survey carried out in 1837 identified that 178 criminal lunatics were being held in various institutions under the 1800 Act. Fifty-five were being held in Bedlam, 48 in county asylums, 35 in private madhouses and the rest in prison (Hutter & Williams, 1981).

The next piece of relevant legislation is the 1808 County Asylums Act, which enabled English and Welsh counties to levy a rate to build asylums, places where lunatics could be better managed than in the previous abodes of prisons and workhouses (Conolly, 1850; Skultans, 1987; Tuke, 1882; Wright, 2000). This is the first piece of legislation that established the Great Confinement of Foucauldian claims (Foucault, 2006) in the United Kingdom, which happened later than its French equivalent, primarily due to the local parish form of government and the lack of a powerful centralized state (Scull, 2006; Symonds, 1995). It became known as 'Wynn's Act' (Baly, 1995; Halliday, 1828; Jones, 1972; Murphy, 2003; Rollin, 2000), as it was promoted by Charles Watkins Williams Wynn, Under-secretary to the Home Office, and laid down specifications for the construction and maintenance of the asylums (Baly, 1995), recommending that they be built outside of towns (primarily to ameliorate against the effects of contagion such as cholera, which was still endemic at this time but also because eminent physicians were to be found in towns (Walk, 1962)), but not so far away that it inconvenienced visitors. There were to be separate wards for male and female patients, as well as dry and airy cells for every inmate (Nolan, 2000). It also identified four classes of lunatics to be provided for: 1) dangerous lunatics detained under the Vagrancy Act of 1774; 2) criminal lunatics detained under the Criminal Lunatic Act 1800; 3) pauper lunatics, detained until this Act in workhouses; and 4) non-pauper or paying patients (Nolan, 2000). It had resulted from a House of Commons Select Committee,

which had convened in the previous year to investigate the lunacy problem (Letchworth, 1889). It was found that there were 2,248 identified insane people in England and Wales, giving an incidence of 2.26 cases per 10,000 population. This was probably an underestimation (Nolan, 2000; Tuke, 1882). Despite the law, however, progress was slow, as in the first twenty years of its operation only nine counties had actually built an asylum (Jones, 2003). The first true county asylum was that at Bedford which opened in 1813 (Mooney & Reinartz, 2009; Walk, 1962).

Following the 1808 Act there were a series of amendments passed that culminated in the County Asylums Act 1828 and the Madhouses Act 1828. The main thrust of the former was that it allowed counties to borrow money in order to build an asylum, but any such money borrowed had to be paid back within fourteen years (Roberts, 1981a). The latter was to replace the Madhouses Act of 1774 but only came into operation in England, Wales being excluded (Roberts, 1981a). Its main thrust was the establishment of the Commissioners in Lunacy, a group of fifteen people (Baly, 1995; Bucknill & Tuke, 1858; Letchworth, 1889; Mackenzie, 1992; Mooney & Reinartz, 2009; Shaw, Middleton. & Cohen, 2007; Tuke, 1882) (five of whom would be physicians, who would be paid for their time) whose duty was to visit all private madhouses in the London area annually and issue licences for their operation (Shelford, 1833). At least three commissioners had to visit each madhouse. Commissioners had to swear an oath before the Home Secretary that they would carry out these duties 'faithfully and impartially'. They could not have any interest in the madhouses they visited and the physician commissioners could not attend any lunatic in a private madhouse unless specifically directed to visit by a friend or relative by whose order the patient was detained. Any commissioner who acquired an interest in a madhouse and continued to act as a visiting commissioner for that madhouse was to be fined £50 (Mackenzie, 1992; Shelford, 1833).

Outside of London, Justices of the Peace in Quarter Sessions held the responsibility for licensing private madhouses, and at least two such visitors were to visit each madhouse every year. The Home Secretary could revoke any licence in England at any time, on the recommendation of the commissioners or county visitors (Shelford, 1833). The cost of such a licence to the owner of the madhouse was to be a minimum of £15. In common with the previous legislation, hiding lunatics away from the visitors was an offence. These official visits could result in the release of confined lunatics, providing that person appeared sane on three separate visits with at least twenty-one days between each visit. Each private madhouse was to have an official visitor's book, which held details of the visits, the 'state and condition' of the house, the 'care of the patients', and such other particulars they thought deserved notice together with their observations. Admissions to these establishments was only to be under the orders of a physician, with an accompanying medical certificate (Shelford, 1833). Usually such certificates required the signatures of two doctors (Mackenzie, 1992), but one could sign in exceptional circumstances, and even then the second signature was to be appended within seven days. Any fraudulent signing of such certificates became a misdemeanour. Furthermore, the clerk to the commissioners (or to the county visitors) was to keep a register of lunatics in the madhouses, and it was the duty of proprietors to inform the clerk of new admissions, discharges and deaths of patients (Shelford, 1833). The county registers had to be forwarded to the clerk of the commissioners, and it was the clerk's duty to provide an annual alphabetical list of all patients detained in madhouses nationally. If any establishment for the insane held more than a hundred patients it was to have a resident physician, surgeon or apothecary. Any house that held less than this number was to have a doctor visit at least once a week. If it held less than eleven patients, the commissioners or visitors could reduce the frequency of medical visits to once a month. The relative of the patient who instituted the stay in the madhouse was to visit the

patient at least every six months, or arrange for another person to do so (Shelford, 1833).

In 1829 the Madhouses Law Amendment Act was passed. This enabled the clerk to the Commissioners of Lunacy to claim expenses for the administration of the 1828 Madhouses Act from the Treasury. Furthermore an annual accounting of the expenses of the Commission was to be placed before parliament (Roberts, 1981a).

The 1832 Madhouses Act transferred the appointment of Commissioners of Lunacy to the Lord Chancellor (Bucknill & Tuke, 1858; Letchworth, 1889), who had become responsible for the property of lunatics under a law change in Charles II's reign (1661) (Roberts, 1981a). Furthermore, two of the commissioners were to be barristers, who would be paid at the same rate as their medical colleagues (Tuke, 1882).

In 1834 the Poor Law Amendment Act was passed by Earl Grey's Whig Government (Plowright, 2006). This replaced the Old Poor Laws of Elizabethan times (Aschrott, 1888; Fowle, 1898; Tuke, 1892; Webb & Webb, 1913). It resulted from the 1832 Royal Commission into the Operation of the Poor Laws (Aschrott, 1888), a group of 26 commissioners who collected data on poverty by visiting parishes and by having people respond to questionnaires (Cook, 2005). The findings of the Poor Law Commissioners, published in 13 volumes, were used to argue that the existing system of poor relief needed a radical overhaul. Changes that were recommended were: separate workhouses for different types of paupers including aged, children, able-bodied males and able-bodied females; the grouping of parishes into unions to provide workhouses; the banning of outdoor relief so that people had to enter workhouses in order to claim relief; and a central authority to implement these policies and prevent the variation in practice which occurred under the old poor law (Aschrott, 1888; Fowle, 1898;

Webb & Webb, 1913). The Act itself established a Poor Law Commission to oversee the national operation of the system (Aschrott, 1888; Cook, 2005; Fowle, 1898; Webb & Webb, 1913). This included small parishes banding together into Poor Law Unions (Aschrott, 1888; Cook, 2005; Fowle, 1898; Plowright, 2006; Webb & Webb, 1913; Wright, 2000) and the building of workhouses in each union for the giving of poor relief. It did not ban all forms of outdoor relief – that is, charity for those who were not housed in the workhouses. Not until the 1840s would the only method of relief be for the poor to enter a workhouse. The workhouses were to be made little more than prisons and families were normally separated upon entering a workhouse. There were a number of provisions that aimed at stopping previous discrimination against non-conformists and Roman Catholics. From the perspective of the care of the insane, one section of the Act, Section 45, stated that dangerous pauper lunatics should remain in a workhouse for no longer than fourteen days before being transferred to an asylum (Mooney & Reinartz, 2009).

This new piece of legislation aimed at dissuading the indigent from claiming relief had little or no effect on the mad. A survey carried out in 1844 found that 44.7 percent of all lunatics in England and Wales were classified as paupers and were resident in workhouses (Corfield, 1995).

It is at this point that moves by the English legal system to control lunatics becomes somewhat superfluous to an analysis of legislation in New Zealand, as New Zealand started to have its own legislation from 1840 onwards. However, it is fair to say that legislation enacted in the early years of New Zealand history clearly reflects what was happening in the ‘Old Country’, and was influenced by the thinking of England at that time.

CHAPTER 4: THE NEW ZEALAND HISTORICAL CONTEXT

4.1: INTRODUCTION

New Zealand as a nation is generally considered to have come into being in 1840 with the signing of the Treaty of Waitangi, which takes its name from the place it was first signed on 6 February of that year (Buick, 1914; Ministry for Culture and Heritage, 2008). This resulted in British law being adopted in the colony. At this point in time there were only about 2050 Europeans in New Zealand, with the Maori population being roughly 80,000 (Statistics New Zealand, 2009).

Pearson (2000) states that the first case of lunacy in New Zealand was in 1841. Unfortunately she does not cite any evidence to support this claim. The claim is also stated in Ernst (1991), who discusses the reasons for legislation around mental illness to be produced as early in New Zealand's history as it was. Brunton (2005) points out that the first lunatics in New Zealand came to public attention because they posed a threat to public safety, they could not look after themselves, or because they had no family to care for them. It is interesting to note that those few lunatics (all of whom must have been Pakeha, since Maori did not avail themselves of psychiatric treatment until later in the century) who found themselves in New Zealand at this time must have created sufficient public nuisance that within six years of colonization legislation had to be passed to have some degree of control over their behaviour. And this in a population of only just over 2000.

The first nurses in New Zealand were untrained and employed at Auckland Hospital (which was really a military establishment) in 1841 (Department of Health, 1971).

Despite the very small European population, by 1844 there was provision for the housing of lunatics at Wellington Gaol and Auckland Hospital, with further provision at other hospitals in the colony (Durie, 2004; Coleborne & MacKinnon, 2006; Ernst, 1991; Kirby & Coleborne, 2002)

4.2: THE LUNATICS ACTS, 1846-1908

The first legislation in New Zealand that directly pertains to the treatment of lunatics is the 1846 Lunatics Ordinance (Albrecht, 2006; Coleborne & MacKinnon, 2006). As the full title of the Ordinance suggests, its main function was to “make provision for the safe custody of and prevention of offences by persons dangerously insane, and for the care and maintenance of persons of unsound mind” (Lunatics Ordinance, 1846). It enabled Justices of the Peace, with two medical opinions, to commit any person who was deemed to be a “dangerous idiot” or “dangerous lunatic” and who had a “purpose of committing suicide or any crime” to a gaol, house of correction or public hospital. The person was to be kept here in “strict custody” until discharged by order of two J.P.s (one of whom had to be one of the two original J.P.s who committed the person) or until they were removed to a public lunatic asylum (of which there were none at this time). Legal advisers and friends were allowed to visit the committed person, and family members could choose to take the committed person into their own care, but had to swear before two Justices of the Peace that they would take due cognizance of “peaceable behaviour and safe custody” of the committed person. Once removed to an asylum, discharge could only occur when two doctors determined that a state of sound mind had returned. The Ordinance also discusses pleas of insanity for criminal acts, and states that if found insane, criminals were to be kept in safe custody ‘until the Governor’s pleasure be known’. Section 8 of the Ordinance sets up a system of official visitors to the places where said dangerous lunatics

and idiots were to be kept. Section 9 states that lunatics who are not dangerous can be committed to an asylum, again if two medical opinions deem it necessary. The costs of removing the committed person to a gaol or asylum were to be met by the Colony, as stated in section 10. Under section 11, if the committed person had sufficient means to be able to pay for their own care whilst detained, then the superintendent of the gaol or asylum could request the person's guardian to release the person's funds in order for that to happen (Lunatics Ordinance, 1846).

From the above, it becomes clear that this primary piece of New Zealand legislation did not require any treatment to take place. Its primary purpose seems to be around criminal activity committed by insane persons, and that such persons should be kept in safe custody. In other words it is more about public safety than any desire to see humane treatment for the insane. It does, however, recognise that specific provision for the insane needed to be put in place, especially public asylums. It is also of interest to note that if the committed person was well-off enough, the cost of the incarceration became theirs. The method of using asylums was derived from English practice, and it appears that colonial administrators of this time preferred this system to the Scottish system, which advocated mixed methods of asylum care and community care (Brunton, 2005). Perhaps the only 'community care' options were limited to Maori.

In Dunedin, three mental patients were the first, in 1851, to occupy the small hospital that had been built after large scale Scottish settlement in the area (Medical Services, n.d.)

The first public lunatic asylum in New Zealand was opened in Karori, Wellington in 1854 (Albrecht, 2006; Coleborne & MacKinnon, 2006; Durie, 2004; Haggerty, 2000). Like most

asylums of the era, it was built on the edge of town. Its funding was from the public purse, and while the word asylum may conjure up pictures of large Victorian edifices, it has to be emphasised that it remained quite small, only housing ten patients in 1861 (Ernst, 1991).

The Select Committee of the House of Representatives on a General Lunatic Asylum (1858) investigated the best way to provide a proper lunatic asylum in New Zealand. The question was whether this should be a system of provincial asylums, or whether it was more expedient to consider a central Colonial asylum. According to Brunton (2005), there were between fifty and a hundred chronic lunatics in the country at this time, and the political feeling was that it might be more humane and efficient to consider centralising their control, as well as being the cheaper option. The Select Committee came up with six main recommendations, which led to the 1858 the Lunatics' Ordinance Amendment Act coming into being. This gave magistrates and justices of the peace the power to issue warrants for the detention of dangerous lunatics. Medical examination to determine whether the patient was sane or not had to be carried out by at least two doctors. If found to be insane, the patient was to be sent to an asylum until discharged by order of a resident magistrate or two justices. The major difference here was that Section 3 provided for those who were insane but not violent to be sent to the asylum, if relatives or friends of the patient applied for it. Discharge for such non-dangerous patients came about if relatives or friends swore to take adequate care of the patient and that the peace would be kept, that is there would be no public disturbance as a result of the patient re-entering the community. If a doctor refused to carry out an examination, he could be fined £50 (Lunatics Ordinance Amendment Act 1858).

The increase in immigration to New Zealand during the 1850s and 1860s resulted in further small asylums opening in Otago and Canterbury in 1863, Nelson in 1864, Auckland in 1867 and

Hokitika in 1872 (Coleborne & MacKinnon, 2006; Durie, 2004; Ernst, 1991). Elder, Evans & Nizette (2005) point out that these establishments were not staffed by nurses, but rather by “ill-educated attendants” (p. 42).

As far as madness among Maori is concerned, only a very few cases had been recognised in the colonial contact period, with the belief of ‘makutu’ (whereby madness was inflicted on another by the use of spells or incantations) being to the fore, and treatment usually consisting of banishment (Coleborne & MacKinnon, 2006). Not until the 1860s did any significant numbers of Maori come to the attention of psychiatric authorities, and most of these appeared at Auckland asylum (known as the Whau) (Coleborne & MacKinnon, 2006). More males than females became subject to asylum life, and it has been theorised that contact with European employers or the police could have resulted in committal to an asylum (Coleborne & MacKinnon, 2006).

The Lunatics Act of 1866 dealt with criminal lunatics. Any insane person who committed a crime could be kept in custody for as long as the country’s Governor deemed fit. Similarly, any prisoner who appeared insane, according to two doctors, could be removed from prison and sent to an asylum (Lunatics Act 1866). Here again the emphasis is not on humane treatment of the mad, but appears to be more about public safety than anything else.

The Lunatics Act of 1868 was “to consolidate and amend the law relating to lunatics”. Its transcript in *Statutes of New Zealand 1868* is 57 pages long, and this is the first piece of legislation that attempts to cover all aspects of mental illness. Thus part I of the Act deals with “proceedings by which lunatics shall be placed under restraint”, in other words the process of

committal to an asylum. Part II deals with public asylums and hospitals and deals with the regulations necessary for the safe custody of committed patients. Part III deals with “licensed houses”, small premises that were to be licensed if lunatics were housed there (the New Zealand equivalent of the private madhouses of 17th and 18th century England). The visiting, transfer and discharge of lunatics is dealt with in part IV of the Act, while part V is around the determination of insanity from a legal point of view. Part VI deals with the administration and management of the estates of lunatics (Lunatics Act 1868). This Act was intended to prescribe who was to control the institutions that housed the mad (as Ernst, 1991, points out, the medical profession), and who was to provide statistics regarding the numbers of lunatics. It did not prescribe what conditions would be like in the asylums. It uses the single category of ‘lunatic’ to apply to “any person idiot lunatic or unsound mind and incapable of managing himself or his affairs and whether found lunatic by inquisition or not”. This definition of lunatic is somewhat tautological – a lunatic is a lunatic. As has been pointed out previously, whilst lunacy was the standard nomenclature for madness throughout the 19th century, there is little evidence to suggest that the moon does in fact have any bearing on mental status, so whilst the term suggests pathology, it is based on a false premise.

It is also interesting to note that there is no mention of danger in this definition; the lunatic has merely to be deemed incapable of managing their own affairs in order to become subject to the legislation. Section 5 of the Act does, however, reintroduce the idea of danger, both to others and to the self. Criminal activity and suicidal intention are both mentioned as methods by which the individual would become subject to the terms of the Act. This is reinforced by Section 10, which empowers the police to detain ‘dangerous lunatics’ at large for the purposes of assessment of their mental state by magistrates, and therefore possible incarceration. Section 21 makes it clear that excessive consumption of alcohol could also result in enforced treatment for

up to a year, a situation that was not unusual at this time, as alcoholism was one of the main reasons for admission to asylums during the latter part of the 19th century.

In 1871 a parliamentary Joint Committee upon Lunatic Asylums recommended that any such institution with more than 100 patients be headed by a qualified medical superintendent. Its other recommendations were:

General government to ensure proper provision for lunatics where provision inadequate.
Appoint specialist psychiatrist to supervise and control all asylums.
Obtain more information before making decision about central asylum.
Improve all asylums, especially Karori (Wellington).

(Brunton, 2005, p.5)

It is from these recommendations that medical control of the asylums ensues, and the medical professions self-appointed expertise in the treatment of mental illness has remained unquestioned since, largely (Ernst, 1991). Psychiatrists today still hold the power to admit, discharge, diagnose and prescribe treatment (Johnstone, 2000), all of which may be against the patient's will, a situation that ensues directly from all the mental health law in New Zealand.

With regard to the condition of Karori asylum, the Chairman of the Joint Committee wrote:

In my opinion, it would tend greatly to the advantage of the Asylum, if the site of it were much nearer the town...The general public, especially ladies, would take much more interest in it, and by contribution of books and encouraging cheerful amusements, they would greatly assist Dame Nature, who in this case appears to be the only physician as regards the *vis medicatrix*

(Mental Health Commission, 2004, p.5).

From the second recommendation, the first medically qualified Inspector of Lunatic Asylums was appointed in 1876, Dr. F.W.A. Skae. By this time the population in the asylums was beginning to outstrip capacity, such that some of the essential comforts and amenities were missing. Skae was concerned about this, but did concede that the wards were immaculately

clean and that the patients were treated humanely (Medical Services, n.d.). An example of one of Skae's reports, on the Dunedin asylum, is available online (PapersPast, 2009). Skae was sacked in 1881 following an investigation into the management of Mount View Asylum (Durie, 2004; Ernst, 1991).

As a companion to the Lunatics Act, the Imbecile Passengers Act 1873 stated that if a Superintendent of any province of New Zealand certified a passenger as

being either lunatic, idiotic, deaf, dumb, blind or infirm, and likely in his opinion to become a charge upon the public or upon any public or charitable institution, the Superintendent shall require [from] the owner charterer or master of such ship, ... a bond to Her Majesty in the sum of one hundred pounds for every such passenger.

If the passenger was later admitted to a public or charitable institution within five years, this bond would be taken as payment for their maintenance (Hoult, 2007; Imbecile Passengers Act 1873). The bond of £100 in 1873 is equivalent to approximately £4000 in today's terms (Robinson, 1997). At first view this appears to be a form of eugenic discrimination, but it appears that such legislation was common at this time, with the United States passing a similar piece of legislation in 1882 (Burch, 2009). One is also led to wonder whether, given the quite large amount of money involved in these bonds, there was ever a case of a passenger being discovered to be an imbecile whilst embarked, and not actually arriving at a port in New Zealand, having been forcibly disembarked by the ship's crew in order to avoid the costs of landing such a passenger in the country. The Imbecile Passengers Act 1882 had similar provisions to the previous Act of 1873, with the attendant penalties on ship's captains who landed imbeciles in New Zealand (Albrecht, 2006; Imbecile Passengers Act 1882).

In 1876, with the abolishment of provincial governments which had previously been responsible for the mental hospitals within their respective provinces, the responsibility for mental hospitals

fell on central government (McLintock, 1966), specifically the Lunacy Department, which had a doctor appointed as Inspector-General of Mental Hospitals (Prebble, 2007). At this point in time, the Department took over responsibility for eight provincial asylums, with a total patient population of 736 (Prebble, 2007).

The Lunatics Act of 1882 is massive, being 65 pages long, and has divisions similar to those of the previous Lunatics Act, with one addition, part II, which deals with habitual drunkards (a major expansion of Section 21 of the previous Act). Thus it supersedes the 1868 Act. The definition of lunatic remains largely unchanged from the previous legislation, but does include the rider “and includes any person detained in any public or private establishment or house in New Zealand, authorized or used for the reception of lunatics under the provisions of this Act”. So if one was living in a place for lunatics, then one was a lunatic! Again, the main thrust of this legislation concerns public safety and the removal of dangerous lunatics from the public arena to places of detention, rather than any real concern about the individual patient.

According to McIntock (1966),

a system of probationer nurses who were young women with a better education and a sense of vocation was instituted at the Wellington and Auckland Hospitals in 1884, but at first no attempt was made to give any formal teaching. Organised teaching for probationer nurses was first introduced at the Wellington Hospital by Dr Truby King in 1888 during the short time he was medical superintendent, and the hospital issued a Nursing Certificate after a four months' course. The recruitment of educated probationers, and the provision of organised training, soon spread to other hospitals

(Nursing, n.d.).

By 1887 the numbers of insane had dramatically increased, with one in every 349 people being adjudged to meet the criteria (Coleborne & MacKinnon, 2006). Most of these appear to have

not been born in the country. If this is the case, then one must assume that many ship's captains would have been paying bonds to the New Zealand government under the terms of the Imbecile Passengers legislation

The Lunatics Act Amendment Act 1891 merely makes some minor amendments to the 1882 Lunatics Act. Section 3 stipulates the amount of space that each patient can expect in their sleeping room, whether in an asylum, hospital or private house. Section 12 makes it clear that the costs associated with care in an asylum for a married woman should fall to the husband, even if she is detained against his will (Lunatics Act Amendment Act 1891).

The Lunatics Act Amendment Act 1894 also makes an amendment to the 1882 Lunatics Act, omitting the words "all of whom shall be Justices of the Peace" from Section 130 of the previous legislation. This meant that official visitors to asylums need no longer be only Justices of the Peace. (Lunatics Act Amendment Act 1894).

In 1901 the Nurses Registration Act was passed, largely through the efforts of Grace Neill, a trained nurse who had been appointed as assistant inspector of hospitals and asylums in 1895 (Dock, 1920; Prebble, 2007). This provided for a course of three years' training and a State examination followed by registration (McLintock, 1966). Three years later a formalised national training for psychiatric nurses was introduced, based on a similar training programme from the United Kingdom (Prebble, 2007). Male attendants and female nurses (note the difference in appellation) could register as mental nurses after three years' employment at a public mental hospital, alongside attendance at lectures and the successful completion of oral, written and practical examinations. As a result of this innovation, the first mental nurses registered in New

Zealand in 1908 (Prebble, 2007).

The next change to mental health law did not come until 1908, with the Lunatics Act of that year. This is another massive piece of law, running to 71 pages. The parts of the Act are:

- I - proceedings to restrain lunatics,
- II – habitual drunkards,
- III – asylums and hospitals,
- IV – licensed and private houses for reception of lunatics,
- V – visitation, transfer and discharge of lunatics,
- VI – de lunatico inquirendo (court enquiries to determine insanity),
- VII – administration and management of the estates of lunatics, and
- VIII – miscellaneous provisions.

It replaced the 1882 Lunatics Act and its amendments. (Lunatics Act 1908). Again its main thrust was the detention of dangerous lunatics. The definition of lunatic did not change from the previous Act.

4.3: THE MENTAL DEFECTIVES ACTS, 1911-1951

In 1911 the law first came to recognise a difference between mental illness and mental disability when the Mental Defectives Act was passed. This replaced the 1908 Lunatics Act. Section 2 of the Act defines “mentally defective person” as:

a person who, owing to his mental condition, requires oversight, care, or control for his own good or in the public interest, and who according to the nature of his mental defect and to the degree of oversight, care or control deemed to be necessary is included in one of the following classes:

Class I – “persons of unsound mind” – that is persons who, owing to disorder of the mind, are incapable of managing themselves or their affairs:

Class II – “persons mentally infirm” – that is, persons who, through mental infirmity arising from age or the decay of their faculties, are incapable of managing themselves or their affairs:

Class III – “idiots” – that is, persons so deficient in mind from birth or from an early age that they are unable to guard themselves against common physical dangers and therefore require the oversight, care or control required to be exercised in the case of young children:

Class IV – “Imbeciles” – that is, persons who though capable of guarding themselves against common physical dangers are incapable, or if of school age will presumably when older be incapable, of earning their own living by reason of mental deficiency existing from birth or from an early age:

Class V – “feeble-minded” – that is, persons who may be capable of earning a living under favourable circumstances, but are incapable from mental deficiency existing from birth or from an early age of competing on equal terms with their normal fellows, or of managing themselves and their affairs with ordinary prudence:

Class VI – “epileptics” – that is, persons suffering from epilepsy.

(Mental Defectives Act, 1911, p. 14)

Class I could be interpreted to mean those who are mentally ill, Class II, those who suffer from dementia, and classes II, IV and V as having some degree, whether slight or severe, of mental disability. This legislation was passed after growing pressure from medical and educational authorities, and the public, to bring these classes of people under control, and had been influenced by the British Royal Commission on the Care and Control of the Feeble-Minded (1908) (Hoult, 2007). It is also interesting to note that at this time epilepsy was still seen as a mental disorder rather than as a neurological disease. The Act gives similar provision for compulsory detention as the Lunatics Acts (Mental Defectives Act 1911). Hoult (2007) points out that eugenics influenced the wording of this legislation, particularly since there had been a rise in popularity of the eugenics movement in New Zealand from 1905 onwards. Perhaps the most interesting part of the definition of ‘mentally defective person’ was “a person who, owing to his mental condition, requires oversight, care or control for his own good or in the public interest...” There is no mention of treatment. Furthermore that a person should require

oversight, care or control for his own good smacks of a thoroughly paternalistic dimension to this legislation on the one hand, while “or in the public interest” yet again implies that public safety was more of a concern than the individual’s recovery. Under this Act it became an offence for anyone to attempt to have sexual contact with a female patient incarcerated under the Act – a far cry from what was happening at Bedlam in the 17th and 18th centuries.

There were several amendments to the Mental Defectives Act over the next forty years (Mental Defectives Amendment Act 1914, Mental Defectives Amendment Act 1921, Mental Defectives Amendment Act 1928, Mental Defectives Amendment Act 1935, Mental Defectives Amendment Act 1950, Mental Defectives Amendment Act 1951). The first of these enabled the discharge of patients from the Act once they were deemed capable of managing their own affairs. The 1921 amendment made some changes to how the financing of a patient’s stay in an asylum was to be funded.

In 1927 psychiatric clinics were established at Wellington and Auckland hospitals (Department of Health, 1971). A year later, the 1928 Mental Defectives Amendment Act added a seventh class of “mental defective” – “persons who suffer from mental deficiency associated with antisocial conduct” (Mental Defectives Amendment Act 1928). Thus behaviour deemed to have an antisocial element could become subject to the legislation. Supplying intoxicating liquor to a mentally defective person, whether or not they were subject to the Act, became a criminal offence.

Insulin coma therapy was introduced to New Zealand in 1938, when it was first used in Seacliff Hospital, near Dunedin, in the treatment of schizophrenia (Prebble, 2007). The treatment had been developed in 1933 by Austrian psychiatrist Manfred Joshua Sakel (Braslow, 1999; Fink,

n.d.; Shorter, 1997; Shorter, 2005). A year later Meduna's carbiadol convulsion therapy (Abrams, 2002; Andre, 2009; Braslow, 1999; Challiner & Griffiths, 2000; Fatemi & Clayton, 2008; Fink, 1999a; Fink, 1999b; Fink, 2004; Getz, 2009; Leinbaugh, 2001) was trialled at Tokanui, Porirua and Sunnyside Hospitals (Prebble, 2007). It was not until 1957 that the treatment was totally discredited (Ackner, Harris & Oldham, 1957)

As Prebble (2007) points out, even at such late a date as 1939, there were very few successful psychiatric interventions available, the one exception being malarial treatment for patients diagnosed with 'general paresis of the insane' (as the effects of tertiary stage syphilis were known). In 1913 Hideyo Noguchi and Stanford Moore of the Rockefeller Institute had demonstrated the presence of *Treponema pallidum*, the causative organism behind syphilis, in the brains of patients suffering from general paresis of the insane (GPI) (Fatemi & Clayton, 2008). In 1917 the Austrian psychiatrist Julius von Wagner-Jauregg had found that malaria-induced fever caused remissions in patients with general paresis of the insane (Braslow, 1999; Fatemi & Clayton, 2008). As a result he became the first psychiatrist to receive the Nobel Prize, in 1927 (Sherby & Odelberg, 2002). This form of treatment reversed the symptoms of general paresis in about one third of cases (Getz, 2009). It was not until the advent of penicillin in the 1940s that syphilis was successfully combated (Rollin, 2000).

Pre-frontal leucotomy, as developed by Moniz in 1935 (Braslow, 1999; Burch, 2009; Fatemi & Clayton, 2008; Shorter, 2005), was first performed in New Zealand in 1942 by a visiting American neurosurgeon (Prebble, 2007). Following this a few operations were carried out each year in hospitals in Auckland and Dunedin, with a gradual increase in the number of operations through the 1940s. This operation was performed with the following rationale: to cure these

patients it is necessary to destroy the arrangements of cellular connections, more or less fixed, that must exist in the brain and particularly those that are linked with the frontal lobes. In other words, this was a form of iatrogenic brain damage. The operation severed the connections of the frontal lobe with the rest of the brain. Egas Moniz won a Nobel Prize in Physiology and Medicine in 1949 for his invention of the procedure (Braslow, 1999; Burch, 2009; Fatemi & Clayton, 2008; Sherby & Odelberg, 2002). According to Johnstone (2000), one of his patients was so impressed with the treatment that he shot Moniz in the spine, thus ending his career.

Electroconvulsive therapy (ECT) was introduced to New Zealand in 1943, being first used at Sunnyside Hospital (Prebble, 2007). Within two years it had largely superseded cardiazol convulsion therapy. Prebble also points out that it was not used purely for therapeutic reasons, but sometimes merely as a means of controlling behaviour. The procedure had been developed by the Italian professor of neuropsychiatry, Ugo Cerletti (1877-1963), and his neuropsychiatrist colleague Lucio Bini (1908-64), who could both see the benefits that convulsive therapy had on severe mental illness, thought that the use of electric shocks to produce seizures would be a preferable and more reliable treatment than chemically-induced seizures (Leinbaugh, 2001). They first experimented on animals to demonstrate the safety of the procedure (Abrams, 2002; Andre, 2009; Null, n.d.) and, in 1938, for the first time on a person, a mute, delusional man who had been found living on the streets of Rome (Abrams, 2002; Andre, 2009; Braslow, 1999; Challiner & Griffiths, 2000; Johnstone, 2000). He showed improvement in symptoms after just one treatment (beginning to speak, although what he did say was far from flattering about the treatment, (Breggin, 1998)), and complete recovery after eleven (Abrams, 2002). However, his wife reported that he relapsed three months after this course of treatment (Andre, 2009). Cerletti and/or Bini were nominated for the Nobel Prize in Physiology or Medicine in 1943, 1947 and 1948, but neither were awarded the prize (Nobelprize.org, n.d.) . According to Johnstone

(2000), Cerletti later came to believe that ECT should be dropped as a treatment.

Published in 1946, Arthur Sainsbury's *Misery Mansion – Grim Tales of New Zealand Asylums* made some sweeping accusations: the government was neglecting mental hospitals and the staff that worked in them were abusing their patients (Prebble, 2007). Although the government denied these accusations, the pamphlet did bring to public attention the state of mental hospitals in New Zealand at this time. This report came four years after a disaster in 1942 at Seacliff Hospital, twenty miles north of Dunedin. Fire destroyed a female ward, taking the lives of thirty-seven patients (Prebble, 2007). This was primarily because the fire occurred at night, when the ward was unstaffed, windows and doors were locked, and the only supervision available was when a nurse from a neighbouring ward visited hourly (due to staffing shortages). Also there was no automatic fire alarm system in place. An enquiry into the disaster found that the hospital needed a major redesign.

Following these occurrences, amendments were made to the Act in 1950 and 1957. The Mental Defectives Amendment Act of 1950 made it compulsory for each establishment that cared for mentally defective persons to have a medical superintendant (who had to be a suitably qualified doctor) (Mental Defectives Amendment Act 1950). Other parts of this Act dealt with how the funding for incarceration was to be collected.

Further strengthening the case for care, the 1951 Mental Defectives Amendment Act made it compulsory for any establishment that housed over a hundred mentally defective persons to have a medical officer living in residence (Mental Defectives Amendment Act 1951).

Despite the introduction of new therapies, the state of care in New Zealand's mental hospitals throughout the 1950s has little to recommend it. As Prebble (2007) points out, physical abuse of patients was still prevalent, usually under the epithet of "thump therapy".

In 1962 the New Zealand government's Department of Health was reorganized into six divisions, one of which concerned mental health. At the same time New Zealand itself was organized into nineteen health districts, each of which came under the control of a Medical Officer of Health (Department of Health, 1971).

4.4: THE MENTAL HEALTH ACTS, 1969-2008

It was not until 1969 that there was any further change to the law. The Mental Health

Act 1969 defined mentally disordered as :

suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:

- a) Mentally ill---that is, requiring care and treatment for a mental illness:
- b) Mentally infirm---that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:
- c) Mentally subnormal---that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.

This definition does not include any mention of danger, which sets this Act apart from previous legislation. It is also the first time there is mention of "informal patients", that is patients that are admitted to a psychiatric establishment without recourse to the Act. Informal patients are therefore not subject to any legal requirement for assessment or treatment, and may leave the hospital at any time providing they do not meet the definition of disordered at the time of the leaving.

Part III of the Mental Health Act 1969 is about committed patients, that is patients that are subject to compulsory detention under the Act. Time limits are set for each applicable section,

something that was not present in previous legislation. Part IV concerns “special patients”, those that are detained in prisons. Part V deals with the care and treatment of mentally disordered persons, and prescribes the rules and regulations that have to be met in the process of that care. Part VI deals with homes for mentally subnormal persons. Part VIII deals with offences under the Act: these included having or attempting to have sexual intercourse with a female patient, and supplying alcohol to a patient. (Mental Health Act 1969).

Over the next few years, there were several amendments to the 1969 Mental Health Act. (Mental Health Amendment Act 1972; Mental Health Amendment Act 1975; Mental Health Amendment Act 1976; Mental Health Amendment Act 1977; Mental Health Amendment Act 1979; Mental Health Amendment Act 1982; Mental Health Amendment Act 1985). Whilst they all made changes to the 1969 Act, none of them were major, and certainly none of them made any changes to the definitions the 1969 Act had made, so for this reason, they have nothing to add in an analysis of such definitions of mental disorder.

The current mental health legislation in New Zealand is the Mental Health (Compulsory Assessment and Treatment) Act 1992. It replaced the Mental Health Act 1969 and was established to:

redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder.

(Mental Health (Compulsory Assessment and Treatment) Act 1992 long title)

Since the passage of this current Act, there have been three amendments. The first came with

the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999. The primary major change here was section 7A, which required a psychiatrist conducting an assessment under the Act to consult with the patient's family or whanau, unless such consultation is impracticable or not in the best interests of the patient (Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999).

The second amendment came with the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2003. This was merely a change of wording in section 122 of the main legislation (Mental Health (Compulsory Assessment and Treatment) Amendment Act 2003).

The latest change to the legislation came with the Mental Health (Compulsory Assessment and Treatment) Amendment Act 2008. It makes changes to the wording of Section 25 of the original Act (Mental Health (Compulsory Assessment and Treatment) Amendment Act 2008).

CHAPTER 5: FINDINGS

5.1: INTRODUCTION

Naturally, due to the nature of discourse analysis, there are many ways of reading the law when attempting to come to any conclusions. However, the main discourse identified that is of major concern to nursing is that of definition. Several of the laws attempt to define both the nature of the condition one has to be diagnosed with, as well as the risk one exhibits from a public safety point of view. Throughout its evolution, the law relating to these definitions has enabled the state to involuntarily incarcerate those that have met the various definitions. With the latest major change to the definitions, nurses have taken on the role of officers of the law. Due to this introduction of the Duly Authorised Officer role into the practice of many psychiatric nurses, these two separate but inter-related discourses must surely be of concern to the profession. Furthermore, because these discourses impact directly on the removal of human rights, they should also be of concern to the general populace of New Zealand.

5.2: LUNACY DEFINED

The Lunatics Ordinance of 1846 merely states that “dangerous lunatics” or “dangerous idiots” should be incarcerated. Having stated this, it makes no attempt to define lunacy or idiocy, but the understanding of these terms surely reflects the medical philosophy and popular thinking of the time. Tuke (1892), for example, defines lunacy as “the legal term representing those deviations from a standard of mental soundness, in which the person, property, or the civil rights may be interfered with, when incapacity, violence, or irregularities threaten danger to the lunatic himself or to others” (p. 752). If this is the sort of definition of lunacy that the law uses, it is clearly unsatisfactory. It states that there is a standard of mental soundness, and informs us that lunacy is a deviation from that standard, but fails to state what is the standard.

Furthermore, it implies that lunacy becomes apparent when incapacity, violence or irregularities threaten danger to the lunatic or others, yet there is no attempt to define what those irregularities may be. Dercum (1918) defines idiocy as “mental deficiency ... the result either of disease or arrested development previous to, at the time of, or within a few years following birth” (p. 21), which is somewhat clearer than any of lunacy.

In legislation revised twenty-two years later, the Lunatics Act of 1868 is no clearer. It defines lunatic as “any person idiot, lunatic or of unsound mind and incapable of managing himself or his affairs and whether found lunatic by inquisition or not”. Thus a lunatic is defines as a lunatic, a tautological definition if ever there was one.

By 1882 the definition of lunatic had changed to “any insane person, idiot, lunatic, or person of unsound mind and incapable of managing himself or his affairs, whether found lunatic by inquisition or not, and includes any person detained in any public or private establishment or house within New Zealand, authorized or used for the reception of lunatics under the provisions of this Act” (Lunatics Act, 1882). Again a lunatic is defined as a lunatic. What is more, this definition states that if one is housed in a place for lunatics, then one is a lunatic. Surely this definition is absurd – where one lives (particularly involuntarily) does not define who or what one is.

5.3: MENTAL DEFECTIVE DEFINED

The Lunatics Act of 1908 made no change to the previous definition. However, by 1911 the current legislation had been re-titled The Mental Defectives Act (1911), and had done away with the unsatisfactory term “lunacy”, replacing it with “mentally defective person” who was

defined, under Section 2 of the Act, as:

a person who, owing to his mental condition, requires oversight, care, or control for his own good or in the public interest and to the degree of oversight, care, or control deemed to be necessary is included in one of the following classes:-

Class I: “persons of unsound mind” – that is, persons who, owing to disorder of the mind, are incapable of managing themselves or their affairs:

Class II: “persons mentally infirm” – that is, persons who, through mental infirmity arising from age or the decay of their faculties, are incapable of managing themselves or their affairs:

Class III: “idiots” – that is, persons so deficient in mind from birth or from an early age that they are unable to guard themselves against common physical dangers and therefore require the oversight, care, or control required to be exercised in the case of young children:

Class IV: “imbeciles” – that is, persons who though capable of guarding themselves against common physical dangers are incapable, or if of school age will presumably when older be incapable, of earning their own living by reason of mental deficiency existing from birth or from an early age:

Class V: “feeble-minded” – that is, persons who may be capable of earning a living under favourable circumstances, but are incapable from mental deficiency existing from birth or from an early age of competing on equal terms with their normal fellows, or of managing themselves and their affairs with ordinary prudence:

Class VI: “epileptics” – that is, persons suffering from epilepsy.

Thus, at this point in the evolution of legislation in New Zealand, specific mention is made of of psychogeriatric problems and epilepsy, neither of which were clearly outlined in previous legislation. The terminology “for his own good” smacks of extreme paternalism, whilst the term “disorder of the mind” provokes debate over firstly what is mind? This question remains, with many scholastic tomes having attempted to define what mind is (Beakley & Ludlow, 2006; Burwood, Gilbert & Lennon, 1999; Carruthers, 1986; Chalmers, 2002; Cockburn, 2001; Crane, 2001; Di Nucci & McHugh, 2008; Feser, 2006; Gallagher & Zahavi, 2008; Gill, 1990; Goldberg & Pessin, 1997; Guttenplan, 1995; Heil, 1998; Heil, 2004; Kim, 1998; Lowe, 2004; Maslin, 2001; McGinn, 1996; McLaughlin & Cohen, 2007; O’Connor & Robb, 2003; Rakova, 2006;

Stich & Warfield, 2003). Since there are many theorists who have argued this question, it follows that there would be numerous theories concerning what is a disorder of mind. Indeed, it could be argued that since there is no concrete proof of the existence of mind, there is likewise no concrete proof of any disorder of it (Moore, 1984). Moreover, even if the existence of mental disorder is taken as fact, many, if not most, people experience symptoms that would be indicative of a disordered mind, without seeking or being subject to psychiatric intervention (Webster & Hucker, 2007). It is also worth noting that epilepsy, today considered to be neurological disorder, was still considered a disorder of the mind in 1908.

The Mental Defectives Act of 1911 made no changes to the definitions in the 1908 Act, but the short title of the Act is worth noting. Defective is defined by the Compact Oxford English dictionary as “imperfect or faulty; lacking or deficient” (AskOxford, 2010b). So this Act, by its title, implies that the minds of people that became subject to it were either imperfect or faulty, or lacking or deficient. Taking the first adjective of imperfect, there is an assumption of perfectness of mind, otherwise how could a mind be imperfect. What would a perfect mind appear like? If faulty, then anyone could become subject to the law, as, at times, we all display faulty mental faculties, such as lapses of memory, slips of the tongue etc. As stated previously most of us experience some ‘psychiatric symptoms’ at some times in our lives without recourse to involuntary incarceration (Webster & Hucker, 2007). Are such demonstrations of faultiness of mind sufficient to precipitate a diagnosis of mental defectiveness? One would hope not, but asking the question is important.

The notion of a lack of mind is an interesting one, given that the possession of a mind is often considered to be one of the unique qualities of humanity (Feser, 2006). A deficiency of mind

implies that there is such a thing as enough mind, otherwise there could not be a deficiency. What is enough mind? What is not enough? How does one ascertain how much mind has to be missing in order to deem a person incapable of self care and control? Is mind, in fact, quantifiable? Again, these questions are rooted in the field of philosophy of mind.

The Mental Defectives Amendment Act of 1928 introduced a seventh class of mental defective: “persons socially defective – that is persons who suffer from mental deficiency, associated with antisocial conduct, and who by reason of such mental deficiency and conduct require supervision for their own protection or in the public interest”. Here again is mentioned mental deficiency – the same questions as posited in the previous paragraph can be asked. Adding to the debate is the concept of “antisocial conduct”. Antisocial is defined by the Concise Oxford English Dictionary (AskOxford, 2010a) as “contrary to accepted social customs and causing annoyance” or “avoiding the company of others”. If, in this case, the former definition is taken, one has to ask the question what is wrong with being contrary to accepted social customs, and, even if one displays behaviours that are contrary to social norms that others find annoying, whose problem is it? The fact that one could be incarcerated for one’s own protection implies that the dangers may in fact derive from others in society, not the person who displays behaviours that are contrary to the other’s view of normality. However, it could also be interpreted that this is another aspect of the legislation that focuses more on ‘safety’ for the majority as opposed to the rights of the individual. This tension between public safety and the rights of the individual will be discussed further at a later stage. If the latter, dictionary definition of solitude (avoiding others) is taken, then wanting to be solitary appears to become a mental defect. This is a far cry from the present legislation which appears to give the right to isolation (Mental Health Act (Compulsory Assessment & Treatment) Act 1992, section 71.

5.4: MENTAL HEALTH DEFINED

The Mental Health Act of 1969 introduced the term “mentally disordered” and defined it as:

“suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:

- 1) Mentally ill---that is, requiring care and treatment for a mental illness:
- 2) Mentally infirm---that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:
- 3) Mentally subnormal---that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.”

Under this definition of mental illness, disability due to dementia or brain injury and intellectual handicap were the conditions that could find one incarcerated. These conditions need not be permanent, but intermittent. Therein lies the origin of an inconsistency that is discussed later, with regard to the definitions of the present legislation. Furthermore, the 1969 Act states that these conditions have to “substantially impair mental health”, but, again, there is no standard to describe what good, unimpaired mental health should look like. With regard to the mental illness part of this definition, there is no clarification as to which of the numerous mental illnesses would meet the criteria for an outcome of such as incarceration, so it is fair to assume that any one could meet the criteria, particularly as, unlike all previous legislation, there is no mention of the word danger. This further implies that one need only be diagnosed with one of the three categories listed above, to find oneself taken away forcibly to an asylum, whether or not one displayed any signs of danger either to oneself or to others.

The most current legislation in New Zealand is the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA 1992). The first thing to say about this legislation is the strangeness of its short title. There are several possible ways to interpret this. Obviously one can interpret it

as it is meant to be read, that in certain circumstances it may be necessary to have compulsory admission of a patient to a hospital for the assessment and treatment of a mental disorder. Conversely, one could interpret the title as it can be read literally, implying that anyone who is mentally healthy needs compulsory assessment and treatment, further implying that a state of madness (chaos) is somehow to be preferred to a state of mental health (order). This smacks of anarchism (Ward, 2004) and surely could not have been the intention of the politicians who passed the law. A third interpretation is somewhat more sinister, and could imply an Orwellian dystopia (Horowitz, 2005) – that the state **will** assess and treat anyone who is deemed mentally disordered until such time as they “toe the line”, an attitude somewhat similar to the abuses of psychiatry that have been perpetrated in such totalitarian states as the U.S.S.R (Gosden, 1997; Kondrat'ev, 1995; Noll, 2007; Spencer, 2000; Szasz, 1994) and Communist China (Lyons & O'Malley, 2002). Furthermore, it is also interesting to note that the term “mental health” is not used at all within the Act, unless it is as part of a more extensive phrase, such as Director of Area Mental Health Services. Yet there are twenty-five mentions of the term “mentally disordered”, suggesting that the MHA is really concerned about pathological conditions, not “mental health”, just as all the previous legislation had been.

The major changes in emphasis from previous legislation contained in the MHA 1992 are described by the Ministry of Health (2000, p.6-7) as follows:

- better definition of mental disorder;
- it dealt only with compulsory assessment and treatment;
- it focused on the need for treatment, not on the need for containment;
- treatment to be provided in the least restrictive environment possible;
- it clarified the rights of those receiving compulsory treatment;
- the importance of cultural identity and beliefs;
- a means to enable people to receive compulsory treatment in the community;
- procedures for the review and appeal of decisions as well as processes to address any breaches of rights.

The Orwellian view of the legislation mentioned earlier could become strengthened when one considers the definition of mental disorder as outlined in Section 2 of the Act:

an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it-

- a) Poses a serious danger to the health or safety of that person or of others; or
- b) Seriously diminishes the capacity of that person to take care of himself or herself.

Mental Health (Compulsory Assessment and Treatment) Act 1992

This has several implications. Firstly there is the issue of abnormality of mind, implying that there is such a thing as normality of mind. Anyone whose mental processes could be thought of as abnormal could fall prey to this definition, including those who are thought of as abnormal because they are “different, deviant, maladapted or non-conformist”, (Bell & Brookbanks, 2005, p. 17) even though there may be no disturbance of mental functioning. This is particularly relevant when one considers the number of different cultures now within New Zealand.

Behaviour that may be viewed as normal for one culture may be considered deviant or abnormal in another, and could hence be viewed as deriving from a mental disorder. Nevertheless, the Ministry of Health stipulates that particular care should be taken to ensure that any such abnormality is really abnormal in terms of the individual’s cultural norms (Ministry of Health, 2000). Conversely, there has to be some agreed-upon standard, otherwise each and every potential patient could argue that their condition is normal for them, and so does not constitute an abnormality.

The second problematic area associated with the 1992 definition is that the abnormality of mind may be “continuous or intermittent”. This would imply, if the latter is the case, then if and when the abnormality is ‘in remission’, the individual cannot be defined as suffering from a disorder that meets the second part of the definition, that is a danger to themselves or others. It could also

be argued that every single citizen of New Zealand could appear disordered at times, thus meeting the intermittent criterion. The Guidelines (Ministry of Health, 2000) indicate that compulsory treatment may be instigated for a person who appears to be free of symptoms in certain circumstances, for example: when there are repeated or prolonged episodes of illness, when there is evidence of violence during periods of illness, when there is an early loss of insight during a period of illness, when there is a pattern of being unable to prevent the illness from developing; and where insight is changeable such that there is an inconsistent ability to make decisions.

Delusion is defined as “a false belief that a person holds which cannot be changed by reason” (Collin, 2005, p.103), or “a fixed, irrational idea not shared by others and not responding to reasoned argument” (Page, 2002, p. 163), or “an irrational and usually unshakeable belief peculiar to some individuals” (Marcovitch, 2005, p. 187). The two important components of these definitions are that the belief is false, and that it is fixed and not open to logical argument (Matsumoto, 2009). The problem with these definitions is that none of them state who has the authority to decide whether or not a belief is false. Clearly the patient does not believe them to be false, otherwise he would not hold them in the first place. So, by implication, the onus must fall on the assessing psychiatrist. Therein lays the rub: psychiatrists have their own fixed beliefs (for example that psychiatry is scientific (Rezneck, 1991)) that other members of society could just as easily hold to be false (Muller, 2008). The responsibility is abrogated to psychiatrists to decide what is a false belief or not.

Furthermore, what of religious belief? Most religions require from their followers a degree of faith, with no proof that the chosen deity (or deities) actually exist. Surely this could be counted

as a fixed false belief that is not shifted by logical argument. An example of this was Joan of Arc, who heard voices from God (which in itself could be interpreted as auditory hallucinations), and, as a result, believed that she needed to drive the English out of France (Bailey, 2003b; Barton, 2006; Blom, 2010; Flinn, 2007; Kent, 2003; Zimmermann & Gleason, 2000). Yet, religious beliefs are specifically regarded as an exclusion criterion from application of the Act.

Section 2 of the MHA 1992 also holds that disorders of mood, perception, volition or cognition must be evident for the Act to be enforced. Disorders of mood is not a controversial term in that it has a clear meaning in psychiatry, pertaining to the conditions of depression, mania and bipolar disorder (Page, 2002). Neither is disorders of perception a problematic concept, as again the term has a clear meaning in psychiatry, being usually interpreted as a euphemism for hallucinations (“perceptions that occur when there is no external stimulus”; Page, 2002, p. 266). That is not to say that all forms of hallucination are pathological, for example those that occur following bereavement appear to be a universal cultural norm (Blom, 2010). Nevertheless, if one should vocalise the fact that the dead are visible, one could find oneself coming under the terms of the Act.

Disorders of cognition and volition, however, are much more problematic. Cognition can be defined as “thinking” or “a thought”. If the latter definition is taken into consideration, then disorders of cognition may come to mean that any thought that someone has, even if not delusional, could become evidence of mental disorder if the examining psychiatrist does not agree with it. A case in point could be racist thinking (Bell, 2004; Eakin, 2000)). One could argue that such thinking is tantamount to a delusion, and some psychiatrists do argue this. Such

thinking could engender “danger to others” and, thus, result in involuntary incarceration. Similarly, the excuse often put forward by sexual offenders, that the victim “was asking for it”, is clearly disordered thinking. There is inherent danger to others in sexual offending, so these behaviours possibly should incur the instigation of assessment and treatment procedures under the Act. Sexual offenders appear to have a higher rate of assessed mental illness than the general population in any case (Fazel, Sjöstedt, Långström & Grann, 2007)

Volition means “exercise of the will”, and, whilst it has no agreed psychiatric meaning “disorders of volition” has come to mean signs and symptoms such as catatonia, stupor, command hallucinations, amotivational syndrome, conversion disorders, sleepwalking and epileptic automatism. Interestingly, amotivational syndrome is often associated with cannabis use (Dominguez, 2004), which again presents something of a dilemma. On the one hand, the use of cannabis per se does not require involuntary assessment and treatment, as substance abuse by itself is one of the exclusion criteria discussed later. However, if one uses cannabis to such an extent that amotivational syndrome becomes evident, then a disorder of volition could be diagnosed. In this case it is also quite significant that amotivational disorder does not prevent the volition of using cannabis in the first place, so the name of the syndrome may be completely superfluous.

If a disorder of volition means that exercise of the will is in error, the mere fact that one could be involuntarily incarcerated because of any of the conditions listed above increases the degree of volitional disorder. Clearly, involuntary assessment and treatment is against one’s will (Rezneck, 1991), so arguably this in itself is a disorder of volition. Furthermore, whilst it is done in jocular fashion, Catherine Tate’s alter ego Lauren Cooper, an argumentative and lazy

teenage girl who gets out of awkward situations by repeating her catchphrase, "Am I bovvered?" or "Look at my face, is my face bovvered? Face? Bovvered?" (Lauren Cooper – Gym, 2008) could easily be considered to have a disorder of volition as she has lost the volition to be concerned about anything at all, and since the character is seen as the perfect expression of a generation of teenagers and their speaking style, this could be interpreted as symptomatic of a whole generation of people with disorders of volition. At the other end of the scale there are situations where impulse control is the issue, and again these would be regarded as disorders of volition (Hollander & Stein, 2006). If one has an impulse to perform an act and resists that impulse, then one is not disordered, but if the ability to resist is absent, then one could be considered to be disordered. This concept is interesting when it comes to issues of substance abuse, where the impulse to continue use of a psychoactive substance outweighs any possible risks to health (Thakkar, 2006). Surely this is a disorder of volition, but substance abuse alone is another of the exclusion criteria of application of the Act.

The same argument could apply to other conditions such as problem gambling (Adamec, 2008; Dickerson & O'Connor, 2005; Grant & Potenza, 2004; Kahn & Fawcett, 2008; Ladouceur & Lachance, 2007; McCown & Howatt, 2007; Plante, 2006) and Internet (Block, 2008; McIlvaine, 2007) or sex addictions (Canning, 2008; Carnes, 1994; Kahn & Fawcett, 2008; Laaser, 2004). The simplest form of therapy for these conditions would be just to say "don't do it", but this does not appear to suffice. Instead there has to be an epiphany whereby the individual concerned realises that they actually have control over their problem and no longer has a disorder of volition.

5.5: EXEMPTIONS TO THE DEFINITION

Specific exemptions to the MHA 1992 are stated and, significantly, these help to further clarify the definition of what does or does not apply. As with the sections previously discussed, however, there are anomalies and inconsistencies.

Section 4 of the 1992 Act delineates the conditions where application of the Act will not occur. For example a person's religious, political or cultural beliefs by themselves do not warrant the Act being applied. Sexual preferences, criminal or delinquent behaviour, substance abuse and intellectual disability are similarly not to be considered in isolation when assessing for mental disorder. Several discrepancies with this section and current psychiatric practice can be highlighted.

Take, for example, the notion of cultural beliefs. By themselves, cultural beliefs cannot be taken as evidence of mental disorder. However, DSM-IV (Diagnostic and Statistical Manual IV) produced by the American Psychiatric Association (2000), and the current diagnostic manual for mental disorders used in New Zealand, has an appendix that lists culturally-bound disorders. These can be defined as "disorders of emotional, cognitive or behavioral functioning (or any combination of the three) that are either caused or shaped by cultural factors" (Levinson & Gaccione, 1997, p. 75). Herein lies a dilemma: the law states that cultural beliefs alone should not give rise to a diagnosis of mental disorder, yet the diagnostic manual states quite clearly that some cultural beliefs are in fact disorders. This is particularly pertinent in New Zealand, where within Maori culture there is the notion of *mate Maori*, or "Maori sickness" (Durie, 2001). This is obviously a culturally bound syndrome in that it is only found in Maori. Generally, the condition can manifest with either physical or mental signs and symptoms, and

ensues largely because of a breach of the Maori laws of tapu. It is also interesting to note that mate Maori is not one of the culturally-bound disorders found in DSM-IV. It has been argued that there is no reason for an American-produced manual to list a New Zealand bound syndrome. Yet the list includes koro (originally from Malaysia, but a similar syndrome is found in China and other countries; Chowdhury, 1996; Fishbain, Barsky & Goldberg, 1989; Levinson & Gaccione, 1997; Matsumoto, 2009; Schroer, 2006; Vaughan, 2002), Arctic hysteria or pibloktoq (from the Arctic, particularly Inuit; Dick, 1995; Kahn & Fawcett, 2008; Levinson & Gaccione, 1997), dhat (from India; Jadhav, 2007; Kahn & Fawcett, 2008), taijin kyofusho (from Japan; Iwase, Nakao, Takaishi, Yorifuji, Ikezawa & Takeda, 2000; Kahn & Fawcett, 2008; Matsumoto, 2009), hwa-byung (from Korea; Park, Kim, Schwartz-Barcott & Kim, 2002), shenjing shuairuo (from China; Kahn & Fawcett, 2008; Lee, 1999; Lee & Wong, 1995), qi-gong psychotic reaction (from China; Hwang, 2007), amok (from Malaysia; Kahn & Fawcett, 2008; Levinson & Gaccione, 1997; Matsumoto, 2009; Williamson, 2007), windigo (from Canada; Levinson & Gaccione, 1997; Matsumoto, 2009; Teicher, 1956), susto (from Central and South America; Levinson & Gaccione, 1997; Matsumoto, 2009; Mysyk, 1998; Rubel, O'Neill, Collado-Ardâon, 1984; Weller, Baer, Garcia & Rocha, 2008), and latah (from Malaysia; Levinson & Gaccione, 1997; Matsumoto, 2009; Melechi, 2003).

A recent case in New Zealand (Bungled exorcism was a crime of love, 2009) highlights this apparent dichotomy of culturally normal beliefs versus mental pathology. It concerns a case of exorcism that resulted in the death of the person being exorcised, Janet Moses. Lawyers for the defence argued that it was a cultural norm for Maori people to believe in 'makutu' (curses) and that the stealing of a lion statue from a local public house could in fact have precipitated such an event, such that the family of the victim felt that they had no choice but to carry out an exorcism

in order to lift the curse. Janet Moses herself is said to have agreed to the procedure, and the defence argument was that the procedure was done out of love, with no malice aforethought. Janet was held down and water forced into her mouth and eyes in order to flush out the demons that possessed her. A 14-year-old girl the group also believed was possessed suffered serious eye injuries as people picked at the demons they saw in them. In fact Moses was probably suffering from mental illness. Clearly there was a danger to self (in Janet's case) or others (in the cases of the accused). Since one of the recommendations of the court was that the accused attend educational courses on tikanga Maori (Makutu death five avoid jail, 2009), there is an implication that what they did was not traditional Maori thinking, and therefore their thinking was outside of a cultural norm. Thus, it could be argued that their actions were based on a fixed false belief, a delusion. Hence the accused could have fallen under the terms of the MHA 1992.

The exclusion of "sexual preferences" is another cause for concern. DSM-IV (American Psychiatric Association 2000) currently lists several sexual preferences, which it names paraphilias (older terminology called these conditions 'perversions' (Roukema, 2003)). These include exhibitionism, fetishism, frotteurism, pedophilia, masochism, sadism, transvestic fetishism, and voyeurism. There is even a category called paraphilia not otherwise specified, which may include, but is not limited to necrophilia, zoophilia, coprophilia and urophilia. Some of these conditions obviously have the potential to be of serious harm to others, such as pedophilia (one in five females and one in ten males are thought to have been molested at some time during their childhood, with family members being the most frequent perpetrators (Roukema, 2003)) and sadism (whereby inflicted suffering is the main feature (Webster & Hucker, 2007)) and, it could be argued, are based on delusional thinking, so could meet the criteria for the Act to be applied. Yet sexual preferences alone are excluded. Once again there is

a dilemma here. Presumably necrophilia would not fall under the terms of the Act, as there is no danger to the victim (they being already dead). Neither would zoophilia be considered dangerous to others, but could fall under the legislation that deals with cruelty to animals, and in any case, as Matsumoto points out (2009), it is considered normal behaviour for young men in some cultures, so could be included in the cultural exclusion. Furthermore, as Roukema (2003) avers, it is extremely unlikely that those who exhibit such practices would voluntarily seek psychiatric help.

Sexual preference has not always been exempt from psychiatric diagnosis. Homosexuality, for instance, only ceased to be seen as a psychiatric illness in 1973, when it was removed from the Diagnostic and Statistical Manual (Shorter, 1997). It had previously been criminalised under the British legal system, with a statute of 1533 classifying sodomy (anal sex) as an illegal activity, whether it be between a male and a female, between two males, or between a male and an animal (King, 2003), and providing for the death penalty (Dynes, 1990). The death penalty was not repealed until 1861, with the last execution for sodomy taking place in 1836 (Pickett, 2009). This law became the basis for all convictions for homosexuality until the passage of the 1885 Criminal Law Amendment Act, which extended the ban to any sexual contact between males. Any male who was found guilty of an act of gross indecency with another male, in public or in private, could be sentenced to prison for up to two years, with or without hard labour. (Female homosexuality has never been subject to legal penalty.) It was this law that caused Oscar Wilde to be imprisoned in the United Kingdom in 1895. Homosexuality was officially classified as a mental disorder in the APA's first *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I) in 1952 (Group for the Advancement of Psychiatry, 2007; Pickett, 2009). There it was designated as a "sociopathic personality disturbance." DSM-II, published in 1968, listed homosexuality as a sexual deviation. Decriminalisation of male homosexuality was

recommended by the 1957 Wolfenden Report, but this did not take place until 1967 (Pickett, 2009), with the age of consent fixed at 21 (five years older than consent for heterosexual sex). As an aside, it is of interest to note that the word ‘homosexual’ was invented in 1892, being first used by the German psychiatrist Richard von Krafft-Ebing in his *Psychopathia Sexualis* (McKee, 2003).

As an exclusion from the MHA 1992, criminal or delinquent behaviour is also controversial. Its relation to mental health is subject to current discussion under the proposal to remove the “provocation” defence from New Zealand law (Should 'provocation' be allowed as a partial defence of murder?, 2009). The whole basis of this defence to a charge of murder is that the accused was provoked by the victim to such an extent as to temporarily lose his self-control: surely this could meet the criterion of intermittent mental disorder.

Substance-abuse is also a borderline area. Whilst substance abuse alone is specifically excluded from the Act, the incidence of drug-induced psychosis is on the increase (Arendt, Rosenberg, Foldager & Perto, 2005). Also, intoxication is often associated with violence (Webster & Hucker, 2007), which is surely one of the criteria of ‘danger to others’, and thus could come under the auspices of the law. Nevertheless, compulsory treatment for alcohol and drug problems comes under the purview of a different piece of legislation, (Alcoholism and Drug Addiction Act 1966).

Similarly compulsory care of the intellectually disabled is covered by different legislation, the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. The Law Commission (1994) had warned that the exemption of mental disability from mental health legislation in the 1992 Act constituted a gap in the law, and that “new legislation concerning intellectually

handicapped people who present a substantial risk of danger to others should be prepared” (p.8).

It is also interesting to note that the MHA 1992 does not specify any of the personality disorders as being subject to the Act. The Law Commission (1994) has argued that the wording of the Act need not be altered to include personality disorder. Yet, some forms of personality disorder result in behaviours that could be dangerous to others or the patient, which implies that these disorders could and possibly should come under the purview of this legislation. Webster & Hucker (2007) identify personality disorders as one of the high risk groups of psychiatric a disorder as far as violence, and therefore danger, is concerned. The Law Commission surmises that should this be the case, the patient could be dealt with under the criminal justice system, as he or she would be legally culpable. Here again there is tension between clinical practice and legislation. DSM-IV lists several types of personality disorder and psychiatrists deal with personality disorders regularly, yet the mental health legislation cannot be applied to such cases. The exclusion of personality disorders from the Act may be as a result of many psychiatric opinions that they are untreatable (Law Commission, 1994), which by itself may be an exclusion criterion for a piece of legislation that concerns compulsory treatment. Another argument that has been for this exclusion is that some recognised personality disorders are normative patterns of behaviour in certain cultures (Winkelman, 2009) and thus have no place in a manual that is supposed to aid in diagnosis of abnormality. Conversely, some of the personality disorders have clear evidence of association with violence, which should make them subject to the mental health law under the ‘danger to others’ criterion (Webster & Hucker, 2007).

Another point of interest is that there are no age requirements for the MHA 1992 to be applied.

This means that children could be subject to the terms of the Act, providing they meet the conditions for mental disorder. This in itself could be problematic when one considers the danger aspect of the definition. What behaviours would a child have to display in order to be considered a danger to society? These criteria may be significantly different to the equivalent risk of danger associated with adults.

5.6: RIGHTS BESTOWED BY THE MENTAL HEALTH (COMPULSORY ASSESSMENT & TREATMENT) ACT 1992

The present legislation is the first in the history of New Zealand that specifically bestows rights on to anybody who becomes subject to it, that is defined as “mentally disordered”, despite at the same time depriving that same person of other rights.

So, given a particular set of circumstances, an individual could find themselves in hospital against their will, subject to assessment and enforced treatment, and, if resistant, to come under “such force as is reasonably necessary in the circumstances” to ensure compliance. This situation clearly removes many civic rights, yet, despite this removal, the same piece of legislation devotes part 6 to patients’ rights. It specifies twelve such rights, which are:

- Section 64: right to information
- Section 65: right to cultural identity
- Section 66: right to treatment
- Section 67: right to be informed about treatment.
- Section 68: further rights in case of visual or audio recording
- Section 69: right to independent psychiatric advice
- Section 70: right to legal advice
- Section 71: right to company and seclusion
- Section 72: right to receive visitors and make telephone calls
- Section 73: right to receive letters and postal articles
- Section 74: right to send letters and postal articles
- Section 75: right to complain about breach of rights.

Whilst this at first glance appears to be an admirable attempt to ensure that the patient retains some rights, if these rights are considered carefully, they are what one would expect any citizen to have anyway. It seems a little ironic then, that the Act has to specify which human rights a

sectioned patient retains. Surely the emphasis should be on which rights they lose, rather than expressing rights that each and every citizen of a civilised country can expect.

On the subject of commonly accepted rights, there is an obvious tension between the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the New Zealand Bill of Rights Act 1990. There are several sections of the latter that appear to contradict the former. For example, section 9 of the latter law talks about the right not to be subject to torture or cruel treatment. This sentiment is seconded by the Law Commission (1994). The MHA 1992 states that once subject to the Act treatment can be instigated, and naturally the choice of treatment falls on the responsible clinician.

There are claims that several treatments used in psychiatry are cruel. Some of these claims come from surprising sources. The Hungarian born American psychiatrist Thomas Szasz (1920-) was one of the main proponents of the anti-psychiatry movement (although he was severely critical of others associated with the movement, such as R.D. Laing (Berlim, Fleck & Shorter, 2003)). Szasz criticized the influence of modern medicine on society, which he considers to be the secularization of religion's hold on humankind (Szasz, 1994). He targeted psychiatry in particular, underscoring its campaigns against masturbation at the end of the 19th century (Szasz, 2003), its use of medical imagery (Cresswell, 2008) and language to describe misbehavior (Farber, 1993; Shorter 2005), its reliance on involuntary mental hospitalization to protect society (Szasz, 2003), or the use of lobotomy and other interventions to treat psychosis.

Szasz believed that “mental illness” was merely a medical metaphor for behaviour that society

viewed as offending, disturbing or shocking (Burch, 2009; Johnstone, 2000; Miller, 2004; Moore, 1984; Shorter, 2005; Vatz, 2004), and that psychiatric diagnoses were only judgments of disdain that supported the use of psychiatric power (Szasz, 1960). Furthermore he felt that disease of any kind had to be demonstrable on the autopsy table, something that cannot be achieved in the field of psychiatry (other in cases of organic psychosis) (Berlim, Fleck & Shorter, 2003; Clarke, 2007; Cresswell, 2008; Dain, 1989; Wynne, 2006), and went on to criticize the fact that mental 'diseases' were only voted into existence by members of the American Psychiatric Association (Szasz, 2000). He viewed psychiatry as a pseudoscience that uses medical terminology to formalise its existence (Slovenko, 2002), but notes that such terminology has only existed over the last hundred years. Psychiatry now persecutes the mad and 'drug addicts' (Szasz, 1994) in much the same way that witches, Jews, Gipsies and homosexuals have been persecuted in the past (Szasz, 1977). The compulsory hospitalisation of the insane he viewed as immoral (Berlim, Fleck & Shorter, 2003; Szasz, 1977), and that no individual should be deprived of their freedom unless they had committed a crime. The fact that the state (wherever that may be) used coercion (Berlim, Fleck & Shorter, 2003; Szasz, 1997; Szasz, 2005; Szasz, 2008) through the use of various pieces of legislation reinforces his idea that psychiatry has become a form of state religion that disguises its legitimacy with claims of being scientific (Szasz, 1994). He also criticised the war on drugs, avowing that the use of psychoactive substances was not a disease, but a social habit, and that it should never be considered a crime, as it was victimless (Szasz, 1996). Despite all this, Szasz has no problem with psychiatry if it is used in a non-coercive manner (Cresswell, 2008).

Although he disavowed any connection with the anti-psychiatry movement (Szasz, 2008), the Scottish psychiatrist R.D. Laing is often named as a proponent (Darton, 1999). His main

criticism of psychiatry was that it was based on a fallacious epistemology (Rezneck, 1991). Mental illness is diagnosed on the basis of behaviour and conduct, yet is treated biologically. He goes on to note that the concept of the medical model of mental illness is actually oxymoronic, as the diagnosis does not follow the traditional medical model. This questioning of the value system on which differences between sane and insane were based led him to argue that the 'mad' were sometimes more sane than the 'normal' (Farber, 1993). He argued that the terminology used in psychiatry was vague, not informing others of the predicament of those that the terminology is meant to describe, and really does nothing more than alienate the normal from the mad even further. With regard to schizophrenia he viewed that it was important to differentiate being 'having schizophrenia' and 'being schizophrenic' (Laing, 1960). Schizophrenia, he argued, was a way of being, one of many possible ways of viewing the world, and that the psychiatric terminology does little or nothing to make that world view understandable (Kotowicz, 1997). Schizophrenia should not be viewed as a disease, since there was no anatomical or biochemical lesion, but should instead be viewed as a reaction to a hopeless situation (the double bind theory of schizophrenogenesis being an example of how this occurred) (Berlim, Fleck & Shorter, 2003; Moore, 1984).

A group that has antipathy to psychiatry are adherents of the scientology movement (Berlim, Fleck & Shorter, 2003; Mieszkowski, 2009). Scientology was founded as a religion in 1954 in Los Angeles (Clarke, 2006; Lewis, 2009; Melton, 2009) by the former science fiction writer L. Ron Hubbard (1911-1986) (McCall, 2007; Passas & Castillo, 1992), and claims to have over seven million adherents (Atack, 1990), although, in reality this figure is closer to 500,000 (Melton, 2009). One of the main tenets of this belief system is that human beings are really immortal spiritual beings (thetans, who reincarnate and have lived on other planets before

coming to Earth (Atack, 1990; Beit-Hallahmi, 1998; Clarke, 2006; Melton, 2009) who have forgotten their true nature. In order to become aware of this 'fact', believers have to undergo a type of counseling known as auditing (Gardner, 1957), in which they aim to consciously re-experience painful or traumatic events from their past, in order to free themselves of their limiting effects (Clarke, 2006). This can only be achieved by the donation of specified amounts of money to the church, and for this reason Scientology is often criticized as a cult that financially defrauds and abuses its members, charging exorbitant fees for its spiritual services (Passas & Castillo, 1992).

Another belief is that psychiatry is destructive and abusive and must be abolished (Atack, 1990; Cooper, 1971; Melton, 2009). Psychiatrists, it is claimed, kill or torture their patients with electric shock treatment (McCall, 2007), use them sexually, and never ever help them. They conspire with governments to control the people, drug children (Citizens Commission on Human Rights (CCHR), n.d. b) or the rest of humanity (CCHR, n.d. n), stifle creativity (CCHR, n.d. h), are responsible for terrorism (CCHR, n.d. a), are coercive in their care (CCHR, n.d. c), abuse the elderly (CCHR, n.d. f), participate in a corrupt industry (CCHR, n.d. j), subvert medicine as a whole (CCHR, n.d. l), erode justice (CCHR, n.d. g), have a host of diagnoses that do not exist in reality (CCHR, n.d. k), create racism (CCHR, n.d. d), assault women and children (CCHR, n.d. m), are anti-religion (CCHR, n.d. q), use deadly restraints in the name of care (CCHR, n.d. e), make massive profits from schizophrenia (CCHR, n.d. o), use therapies that are in fact harmful (CCHR, n.d. p) and destroy young minds (CCHR, n.d. i). Scientologists have even blamed psychiatry for the 9/11 terrorist attacks on New York (1888 Press Release, 2009).

Perhaps the most notorious of advocates for scientology's stance on psychiatry is the American actor, Tom Cruise. In 2005 he criticised Brooke Shields for her use of paroxetine in her postpartum depression, stating that depression was not due to a chemical imbalance, and that psychiatry was a pseudoscience. Later, when interviewed for *Entertainment Weekly* magazine, he voiced the opinion that psychiatry was a Nazi science (Contact Music, 2005), a view that appears consistent with scientological belief (McCall, 2007). It is worth noting, from a New Zealand perspective, that the second local church of scientology opened, not in the USA, but in Auckland, in 1954 (Atack, 1990).

Clearly then, opinions as to the efficacy and or degree of danger associated with psychiatric treatment vary considerably. Take for example, electroconvulsive therapy (also known as electroplexy or ECT). It is a well established, yet controversial treatment (Leinbaugh, 2001) which presents mental health workers with one of the many ethical dilemmas associated with the field of psychiatry. The controversy behind this treatment is that it electrically induces epileptiform seizures in most, but not always, anaesthetised patients (Abrams, 2002; Andre, 2009; Challiner & Griffiths, 2000; Gomez, 2004; Rudorfer, Henry & Sackheim, 2003), apparently for therapeutic effect, whilst there is substantial evidence that it in fact does more harm than good. Unmodified ECT was the particular variety of the treatment that patients from Lake Alice Hospital near Wanganui had complained of, resulting in compensation in 2001 (Flint, 2005).

A British survey (Department of Health, 2003) found that 71% of patients who had ECT were women. This is explained away by the assertion that depression is more commonly diagnosed in women than in men, and thus more recipients of ECT are likely to be female (Rudorfer, Henry

& Sackeim, 2003). Others, however, see this as simply another expression of violence towards women (Burstow, 2006a; Burstow, 2006b), a continuation of the witch craze of earlier centuries. A report on mental health by the Surgeon General said that patients should be warned that the benefits of ECT are short-lived if further treatment in the form of drugs or further ECT is not instituted (a finding that was confirmed by Kellner, Knapp, Petrides, Rummans, Husain, Rasmussen, Mueller, Bernstein, O'Connor, Smith, Biggs, Bailine, Malur, Yim, McClintock, Sampson & Fink, 2006, and again by Tew, Mulsant, Haskett, Begley & Sackeim, 2007) and that there may be some risk of permanent severe memory loss after ECT (Surgeon General, 1999). In New Zealand, ECT can be given without the patient's consent, providing the treatment is considered to be in the interests of the patient by a psychiatrist (not the responsible clinician, meaning the treating doctor) who has been appointed by the Review Tribunal (Mental Health (Compulsory Assessment and Treatment) Act, 1992). This piece of legislation also states that otherwise informed consent must be sought before treatment is commenced. It is difficult to imagine many people consenting to a treatment that is not universally used nor recommended (Rudorfer, Henry & Sackheim, 2003), whose means of action cannot be explained (Rudorfer, Henry & Sackheim, 2003), that may cause brain damage (Benbow, 2004), definitely causes amnesia (Null, n.d.; Rose, Fleischmann, Wykes, Leese & Bindman, 2003), increases the risk of suicide (Andre, 2009; Munk-Olson, Laursen, Videbech, Mortensen & Rosenberg, 2007), doesn't have any long term beneficial effects (Prudic, Olfson, Marcus, Fuller & Sackeim, 2004), and might not work at all anyway (Ross, 2006). Prebble (2007) mentions the fact that when ECT was first introduced into New Zealand patients were often terrified of the treatment and had to be literally dragged to the place where it was being given. Given the nature of the effects that ECT has, one can only suggest that the patients who acted thus were not acting unreasonably, and an argument could be made that the institutions that enforced such

treatment were in fact the 'mad' ones, not the patients who were to endure such treatment.

Breggin (2008) gives evidence against some other of the common psychiatric therapies.

With such controversy surrounding psychiatric treatments, the tension between the MHA 1992, which in effect sentences the patient to endure such treatment, and the New Zealand Bill of Rights Act, which forbids cruel treatment, becomes concerning.

Other anomalies exist between the two laws. Section 10 of the New Zealand Bill of Rights Act says that every person has the right not to be subjected to medical or scientific experimentation without that person's consent. Yet, those with mental disorder are experimented on daily, in that their individual responses to the prescribed treatments cannot be predicted, so each time a treatment is administered it is experimental.

Section 11 of the New Zealand Bill of Rights Act says that anyone has the right to refuse to undergo any medical treatment. Clearly this is not the case if one is considered mentally disordered, as treatment is not only compulsory but force may be used to ensure compliance with that treatment.

Section 13 of the Bill of Rights Act specifies that everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference. However, if one's thoughts and beliefs constitute a danger to others, or oneself, then the MHA may be invoked.

Sections 17 and 18 of the Bill of Rights Act talk of freedom of association and freedom of movement, but both of these rights may be rescinded if one is mentally disordered, particularly since one might find oneself subject to seclusion in a locked room.

Lastly, section 23 of the Bill of Rights Act makes mention of the fact that if arrested, a person shall have the right to consult and instruct a lawyer without delay and to be informed of that right. Whilst under the Mental Health Act there is a right to legal advice, the words “without delay” are not part of the relevant section. So, from a legal advice point of view, a person who is arrested appears better off than one who is mentally disordered.

5.7: DANGER DEFINED

A strong theme running through the legislation pertains to discourse about danger. The discourse of danger to self or others underlies all the legislation in New Zealand, from 1846 to date, with one exception, the Mental Health Act of 1969, which did not mention danger at all. This omission (whether deliberate or accidental) was rectified with the passage of the Mental Health (Compulsory Assessment and Treatment) Act of 1993.

Danger is notoriously difficult to predict in any case, and in the field of mental disorder is even more so (Law Commission, 1994; Pinard & Pagani, 2004), with predictions likely to have only a 50% rate of accuracy. Research has shown that generally, as far as prediction of violence is concerned, practitioners tend to overestimate risk (Webster & Hucker, 2007). The second compelling issue here is that there is an onus on psychiatrists to predict danger, and if they do anticipate it, then the Act should be invoked. This is one of the few cases of law where an offence need not have been committed yet, but legal sanctions can be applied. In almost all other cases of law the offence has to be committed prior to legal sanctions being applied. Also, as the Law Commission (1994) points out, the person who is committed under the Act has little or no chance to disprove the accusation of danger, in opposition to those who are called dangerous under criminal law. Furthermore, as Webster & Hucker (2007) point out, there is a major difference between an ad hoc assessment of risk undertaken at initial interview, and that

undertaken over a period of weeks or months on someone who is involuntarily hospitalized.

The terminology “health and safety” within the current law (MHA, 1992) is comprehensive in that it could imply not only physical harm, but also emotional and psychological harm (although the Law Commission’s report of 1994 only talks about physical harm). So, for example, this could mean that if a person’s mental disorder creates fear and apprehension in others, it would be sufficient reason for the Act to be invoked. This in itself could be problematic, especially when one considers that there is still a great deal of stigma and discrimination surrounding mental health issues (Hinshaw, 2007), so it seems likely that certain echelons of society would feel fear and apprehension at the mere mention of the words ‘mental illness’, without any actual risk to their wellbeing being evident. Since ‘others’ is not limited to just those that the patient has direct contact with, any citizen who feels fear and apprehension could instigate the assessment and treatment process. Bell and Brookbanks (2005; p. 24) identify that certain criteria are relevant when assessing the likelihood of danger:

- 1) Level (that is, the gravity) of the harm should it eventuate;
- 2) Likelihood of the harm occurring;
- 3) Proximity of the harm;
- 4) Frequency of the harm; and
- 5) The need to balance the nature of the harm against the proposed intervention.

Another aspect to the danger issue is that some disorders that are listed in the diagnostic criteria manuals but would publically be deemed to be relatively “safe”, such as caffeine withdrawal or premenstrual dysphoric disorder, can, in very rare circumstances, manifest with violence (Webster & Hucker, 2007).

Danger to oneself is also an interesting idea. This notion only appears to be relevant with regard

to mental disorder. There are many examples of human activity which have dangerousness as side effects, such as smoking, sporting activities, overeating leading to obesity and diabetes, international travel and so forth. Yet not one of those activities is warranted as needing compulsory treatment. Even if they did, the fact that these activities remain popular leads one to speculate that even if such treatment was instigated, there would inevitably be a large number of 'non-compliant' patients. With regard to some of the more medically oriented activities listed above, it is also interesting to note that if the patient autonomously elects for treatment, as in the case of obesity for example, the patient retains the right to veto any particular form of treatment (Sjöstrand & Helgesson, 2004). This same right does not apply to those with disorders of the mind. In practice, danger to oneself most often means that one is suicidal. However, the recent case of Margaret Page, who starved herself to death (surely a suicidal act), apparently did not come under the auspices of mental health law, as she was deemed not to be suffering from a mental disorder, even though she was determined to die (Margaret Page dies in rest home after 16 days, 2010). This has certain implications. Apparently one can do away with oneself providing two criteria are met: firstly that the death is protracted and in no way precipitous, and secondly that one does not mention anything that could be construed as a psychiatric symptom.

Richter & Whittington (2006) state that some of the practices that are demonstrated on mental health wards can increase the risk of 'danger'. The first of these is the so-called "closed-door policy", whereby entry and egress to the ward is through a closed and often locked door. This policy is not only applied to patients who come under the auspices of mental health legislation, but also to voluntary patients. Secondly there is the use of seclusion, or enforced isolation, a situation that is known to increase sensitivity to external stimuli, hallucinations and delusions (Richter & Whittington, 2006) and it could lead to "greater morbidity and mortality than

alternative drug or non-drug approaches” (Sailas & Fenton, 2005, p.10). Alongside this is the removal of personal possessions and close monitoring, such as in the case of visits to the toilet or bathing. Furthermore, research has concluded that as much as 86 per cent of violent assaults on ward staff were preceded by the staff member delivering stimuli that precipitated the violence in the first place (Whittington & Wykes, (1996). So, feasibly, even if one entered the ward voluntarily, sufficient provocation from staff could find the patient demonstrating aggression, and therefore becoming dangerous and so subject to the Act.

Generally speaking the public at large have positive attitudes towards compulsory admission (Kjellin & Nilstun, 1993; Lauber, Nordt, Falcato & Rössler, 2002). Perhaps it is because of this public attitude that the notion of ‘danger’ remains in the current law, despite the fact that prediction of danger is fraught with problems. Furthermore, the same public is far more likely to agree with such coercive ‘treatment’ if the person so-affected is considered a danger to themselves or others (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Wolff, Pathare & Craig, 1996). How much of this is due to the media’s negative depictions of mentally ill people and their ‘association’ with violence (Lomas, 2010; Gavin Dash murder file, 2010; Man acquitted of murder after found insane, 2008; Murder among the martini set, 2010; Murder suspect deemed insane, 2003; The Raurimu Rampage, 2010) remains to be discovered.

Related to the discourse of danger, and running beneath the motivation and need to define mental disorder in the first place, is the discourse of enforced treatment. This term does not appear in the Lunatics Ordinance of 1846, nor its amendment of 1858, both of which only talk about custody. Treatment therefore was not a legal option. Nevertheless, the treatments of the time would have been enforced, from a medical point of view: straitjackets, manacles, bleeding

and so forth. In fact, it was not until the enactment of the Lunatics Act of 1908 that treatment of any kind was mentioned in the legislation, and even then it does not appear to have been a legal requirement. This further enforces Brunton's (2005) assertion that lunacy came to the public attention as a law and order issue rather than a medical intervention.

The Mental Health Act of 1969 is the first legislation that specifically has sections relating to custody and treatment, thus making treatment legally binding. By this time of course, the psychiatric profession had far more weapons in its armoury, including electroconvulsive therapy, insulin coma therapy, lobotomy and leucotomy, the phenothiazine neuroleptics with all their attendant hazards such as tardive dyskinesia, drug-induced parkinsonism and neuroleptic malignant syndrome (Aronson, 2009; Lieberman & Tasman, 2006; Mann, Caroff, Keck & Lazarus, 2003; Roukema, 2003), and the mono-amine oxidase inhibitors which ameliorated depression, but only if you were careful with your diet (Aronson, 2009; Lieberman & Tasman, 2006; Roukema, 2003). Any one of which, or in many cases more than one, could be prescribed by the receiving psychiatrist.

The current legislation continued in similar vein, with sections that specify compulsory assessment and treatment. These vary in duration, with the longest being indefinitely applied community compulsory treatments orders (Section 29, MHA 1992). Treatments have ameliorated. ECT is no longer applied unmodified (Abrams, 2002). Insulin coma therapy (Sabbatini, n.d.) and brain surgery (Lesse, 1984) as treatments for madness have disappeared. The newer antipsychotics have fewer side effects, allegedly, if one discounts massive weight gain (Csernansky & Lauriello, 2005). Antidepressants no longer have dietary requirements (Aronson, 2009; Mitchell, 2004), but probably do not work anyway (Borley, 2008; Kelley,

2010). Yet the newer therapies are still enforced, despite the fact that few, if any, are curative, but merely 'manage symptoms' (Johnstone, 2000).

CHAPTER 6: CONCLUSION – IMPLICATIONS FOR NURSING

The previous chapter has highlighted the fact that none of the definitions used within the various laws have been particularly satisfactory, and have always been more about public protection from the mad rather than any genuine concern for the patient. Furthermore, the medical treatments to which the incarcerated patient may become subject have questionable merit, despite the rise in power of psychiatrists over the past three hundred years (Johnstone, 2000). So what role should nurses have within this flawed situation?

Part 1 of the MHA 1993 deals with the process by which a person may be compulsorily detained in a place of safety, usually in practice a psychiatric ward for the assessment and treatment of a mental illness. This part of the Act has a great deal of influence on mental health nursing practice, especially as psychiatric nurses are usually the proximate enforcers of the law. In the first place most of the officers that are empowered by the law to arrange such assessments, the Duly Authorised Officers (DAOs), are nurses. The Act gives no guidance as to which professions can or cannot be DAOs, merely stating:

Duly authorised officer means a person who, under section 93 of this Act, is authorised by the Director of Area Mental Health Services to perform the functions and exercise the powers conferred on duly authorised officers by or under this Act.

(MHA, 1993, Section 2)

The Guidelines (Ministry of Health, 2000) only state that they should be “competent and appropriately trained health professionals”. They do go on to say, however, that “DAOs are the front-line operators of the Act”.

The year 1952 saw the publication of Hildegard Peplau’s book *Interpersonal Relations in Nursing*. She had actually completed the book in 1948, but publication was delayed because at

that time it was considered too controversial for a nurse to publish a book without a doctor as co-author (Hildegard Peplau Nursing Theory homepage, 2007). Nevertheless, when it appeared it was the first time that the notion of the nurse as a therapeutic agent in the field of mental illness was mooted. One of the main reasons, it seems, for Peplau to devise her model in the first place was to differentiate between what doctors did, using the medical model, and what nurses did (or, at least, should do), using a much more psychotherapeutic model. The medical model, for example, deals with illness, which is seen as a problem within the patient. This illness is manifested in 'symptoms', which are clustered together to form syndromes in the hope of some degree of classification, and is treated in the anticipation of returning the patient to his state of being before the illness (Johnstone, 2000). Peplau's model, on the contrary, deals with the person, not the illness, which in any case is seen in terms of its cultural context, as well as how relationships are affected. For this to work, there has to be the development of a relationship, with the overall aim of attempting to understand the patient and assisting them in their growth. Despite this model being one by which mental health nurses are to be guided, research has shown that less than 7 per cent of mental health nurses' work time was spent in potentially psychotherapeutic contact with patients (Whittington & McLaughlin, 2000).

As mentioned previously, the fact that most DAOs are nurses, who should be guided by Peplau's interpersonal theory, gives rise to a dichotomy. On the one hand, Peplau's model thrusts the nurse forward into the role of therapeutic agent, with the attendant roles that her model recognises. On the other hand a DAO has a legal responsibility, in effect, to protect the public at large from 'dangerous' patients, or, indeed, those same individuals from themselves (Sjöstrand & Helgesson, 2004). One could argue that enforced hospitalization *per se* is not a therapeutic strategy, even though it may result in therapeutic measures. On the contrary, it is a function that the state requires to be fulfilled, and very few, if any, patients who are so

incarcerated are likely to see this as of therapeutic value at the time of their admission.

Mental health nurses may find this dual role difficult to deal with: am I a therapeutic agent or am I a state official that can instigate enforced hospitalization of those whose behaviour goes contrary to public norms and values? Ironically, in some cases, the very nurse who institutes those proceedings may, at a later point in time, find themselves acting as therapy for that patient as 'key worker'.

At this point one could spend a great deal of time arguing that since it is the state that requires statutory admission, it should be as direct agents of the state that DAOs are employed, rather than as dually roled nurses. Leave the therapy to nurses: DAOs are a different beast entirely. Indeed, under some legal systems, nurses do not operate the law, but it is social workers who have the legal responsibility of incarceration (as, until 2007, was the case in the United Kingdom, where 'approved social workers' carried out the functions of the mental health legislation, whilst nurses could remain therapeutic (Mental Health Act, 1983)). Some go further and argue that enforced treatment of any kind should not come under the purview of health authorities (Sjöstrand & Helgesson, 2004), and that interests other than the patient's own become secondary in importance, thus rendering the "danger to others" criterion for enforced treatment somewhat redundant. The same authors also posit the question whether dangerousness should be included as a criterion at all, since the majority of violent acts are carried out by those without mental disorder. What is more, if danger is still to remain part of the criteria for enforced treatment, it further implies that danger is treatable.

Duly Authorised Officers are likely to be the first people to respond to a request for

assessment, and as such they may be required to provide “expert information and advice on the mental health needs and services that may be required by people who are experiencing mental health difficulties and, where appropriate, to facilitate the assessment of a person or proposed patient”.

Under section 8A of the Act, the application for assessment of a person under the Act can be made by anyone over the age of eighteen who has seen the proposed patient within the last three days. It is the duty of the DAO to receive the initial section 8 application, to ensure that they are satisfied that the proposed patient may be mentally disordered under the terms of the Act, to make the application himself or herself under section 8 of the Act if necessary and to arrange for a medical practitioner (most commonly the patient’s general practitioner) to assess the patient with regard to a potential certificate (section 8B) that the medical practitioner agrees there are grounds for believing the patient to be disordered.

Section 9 of the Act instructs the DAO to arrange for the assessment by a named psychiatrist to take place, naming a date, time and place of assessment, and to ensure that copies of every legally required document throughout the procedure are given to the patient in the presence of a member of the patient’s family. During this process the DAO has the right to request police assistance if it is needed (Section 41), and the duty to arrange transportation of the proposed patient to the place of assessment (Section 40) (Ministry of Health, 2000) and to inform the patient of his rights under the Act.

From this, it becomes clear that once an application is received, it is the Duly Authorised Officer who can determine whether or not to set the committal process in motion. If the person being assessed is deemed by the psychiatrist to be mentally disordered, then henceforth the Duly Authorised Officer plays no direct role in the process, but other nurses may now have a role, as the patient is most likely to be detained on a psychiatric ward. Here the role under the

Act is largely one of ensuring that the patient remains on the ward for as long as is legally deemed necessary (which depends upon to which section of the Act the patient is currently subject). This in itself may give rise to ethical dilemmas, especially around the use of restraint should the patient attempt to leave, as “all reasonable steps to detain” (Section 112) should be taken. Section 122B states that anyone in the course of their duty detaining a patient may use “such force as is reasonably necessary in the circumstances”. These sections again fly in the face of therapeutic intervention, as they imply that whatever physical restraint is necessary to restrain the patient is allowed under the law.

The other part of the Act that directly pertains to nurses is Section 111, which outlines the powers of any nurse in situations where they believe an emergency assessment under the Act is necessary. Basically, this section says that any nurse, should they have reasonable grounds to believe that any person admitted to a hospital (not just psychiatric wards) or brought to a hospital is mentally disordered, can arrange for an emergency assessment by a medical practitioner, and can detain the person for up to six hours from the time when the nurse first calls for the medical practitioner, such that the assessment can take place. Again “all reasonable steps to detain” (Section 112) can be taken.

Clearly then, the legislation that has been looked at here has a large part to play in the practice of psychiatric nurses. They either initiate the process by which one of their fellow citizens is deemed to be of unsound mind and too much of a risk to be at large, or they enforce the law and ensure that those subject to it do not escape from their legally binding assessment and treatment, or, if they should, are returned post haste. In the process of reading and re-reading the various pieces of legislation for the completion of this thesis, it became apparent that they were all flawed in some way, with the use of language being open to various interpretations and

misinterpretations.

Initially nurses had no legal role with regard to mental disorder, but gradually they have assumed more responsibility. Today they have a significant role. Yet they continue to work in two opposing roles: that of therapist versus that of custodian. This with legislation that, despite the influence of political correctness so that it sounds as if it is about mental health, continues to be about mental illness. Legislation that enforces treatment. Treatment that nurses often dispense. Just as the treatments of the past appear quaint, ridiculous or morally reprehensible today, who is to say that the treatments of today will not appear equally unconvincing in the future? And that nurses, who aided in the enforcement of such bizarre therapy, will not be held responsible?

At this point is it worth quoting Susie Crooks, who, in July 2009, wrote about the upcoming review of the current legislation (Crooks, 2009, p. 1):

Before I had experienced compulsion myself I would have thought 'So what, psychiatrists know what's best for the mentally ill and we in the community need to feel safe. Forcing the mentally ill to take their medication keeps them well'. In 1994 I had a nervous breakdown after losing a baby.... I was put in a secure lock-down ward in a small cell with a thin rubber mattress on the floor and a cardboard disposable bucket to use as a toilet. The ward was very noisy with people crying and shouting and banging on the walls, no one said a kind word to me or explained what was going on.... I remember being held down by two male nurses while a third person injected me. In my distressed state I thought I was in prison. There wasn't anything to suggest this was a place of healing; no flowers, no visitors, and no kindness. It was a place of punishment, full of cruel, inhuman or degrading treatment.

So far, what Ms. Crooks has written could equally have been written by a patient of Bedlam in the time of Defoe. Nothing much seems to have changed over four hundred years.

She continues (p.1):

I once heard a psychiatrist state that human rights amongst patients interfere with clinical treatment.... The 1992 Mental Health Act does nothing to protect the human rights of people experiencing madness... Mental health is the only area of medicine where the law is used as a way of forcing compliance.... Containment, seclusion and forced medication should be seen as service failures and reported as critical incidents...

This reinforces the argument that all legislation on mental health issues that has come into force in New Zealand is more about the safety and protection of society in general, rather than the humane care and treatment of those experiencing madness. Those of us in the nursing profession who choose to work with those who do have such illnesses must consider carefully whether we wish to remain agents of therapeutic change or officers of the law. To go with the *status quo* and help to enforce the state's requirement to sequester the mad and subject them to "a place of punishment, full of cruel, inhuman or degrading treatment" (Crooks, 2009, p.1) does not appear to be justifiable ethically.

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APPENDIX A

This thesis analysed the following laws of New Zealand (in chronological order):

Lunatics Ordinance, 1846
Lunatics Ordinance Amendment Act 1858
Lunatics Act 1866
Lunatics Act 1868
Imbecile Passengers Act 1873
Lunatics Act 1882
Imbecile Passengers Act 1882
Lunatics Act Amendment Act 1891
Lunatics Act Amendment 1894
Lunatics Act 1908
Mental Defectives Act 1911
Mental Defectives Amendment Act 1914
Mental Defectives Amendment Act 1921
Mental Defectives Amendment Act 1928
Mental Defectives Amendment Act 1935
Mental Defectives Amendment Act 1950
Mental Defectives Amendment Act 1951
Mental Health Amendment Act 1954
Mental Health Amendment Act 1957
Mental Health Amendment Act 1958
Mental Health Amendment Act 1959
Mental Health Amendment Act 1961
Mental Health Act 1969
Mental Health Amendment Act 1972
Mental Health Amendment Act 1975
Mental Health Amendment Act 1976
Mental Health Amendment Act 1977
Mental Health Amendment Act 1979
Mental Health Amendment Act 1982
Mental Health Amendment Act 1985
Mental Health (Compulsory Assessment and Treatment) Act 1992
Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999
Mental Health (Compulsory Assessment and Treatment) Amendment Act 2003
Mental Health (Compulsory Assessment and Treatment) Amendment Act 2008