

Leadership and innovation in New Zealand's mental health system (A)

Stepping into the role of New Zealand's Director of Mental Health in the early 1990s was, Dr Janice Wilson recalled, a baptism of fire. A new government had begun a programme of radical health sector reform, built on competitive commercial principles and the separation of funding from service provision. A decade-long overhaul of New Zealand's mental health legislation had just concluded with the passing of a new Mental Health Act that, despite earlier controversy, championed "treatment in the least restrictive environment." The first-ever national mental health strategy was nearing completion, providing a long overdue policy framework for the sector.

Beyond the Ministry of Health, mental health services were in turmoil, struggling with the consequences of a forty-year drift towards deinstitutionalisation, and long-term under-funding. Prompted by new clinical approaches, new thinking about mental illness, and advocacy about individual rights and liberties, many long-established mental hospitals had closed or were closing. But for the thousands discharged from hospital, alternative community-based services were few and scantily resourced. Some former patients lived in dismal inner-city boarding hostels with little medical or social support, and others with relatives ill-equipped to cope with the demands of care. Public attitudes to mental illness were still characterised by fear, ignorance and "nimbyism": the same sentiments that had once consigned the mentally ill to remote asylums now inhibited their integration into the community.

Meanwhile, sensational headlines about violent crimes committed by former mental hospital patients, and the apparent difficulty of detaining them under the new Mental Health Act 1992,

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were fuelling public anxieties. By 1995, politicians were forced to turn their attention to the sector long regarded as the “Cinderella” of health. That year, Health Minister Jenny Shipley appointed retired judge Ken Mason to head a wide-ranging ministerial inquiry into the state of the mental health system. It was the eighteenth mental health investigation since 1988.¹

Two significant earlier inquiries had been carried out by Judge Mason himself. His 1988 report had led to political acceptance that responsibility for people with major mental illness who committed crimes lay with Health, and not with Justice; this led in turn to the establishment of nationally-coordinated, regionally-managed forensic psychiatric services. The 1988 report had also urged area health boards to address the need for community mental health services but, without dedicated funding or agreement on service models, progress had been patchy.²

Janice Wilson came into this increasingly fraught environment in 1993, after a career as a clinical psychiatrist during the years when deinstitutionalisation (see also *Appendix A*) was in full swing. She had been medical superintendent of Porirua Hospital near Wellington, the largest psychiatric hospital in the country, and later manager of mental health for the Wellington Area Health Board. Her professional experience had convinced her that deinstitutionalisation was the right course. Large, isolated institutions where people lived for years with little hope of recovery were, she believed “no longer acceptable as part of a modernising mental health system.”³ Now, though, she was the public face of a mental health system that was under attack for closing down institutions without establishing adequate alternatives. When the Mason Report was released in 1996, it said a main contributor to the system’s failure was a lack of national leadership.

Janice Wilson saw the furore surrounding the Mason Report as an opportunity to move the debate on. Deinstitutionalisation had happened and could not be reversed. Moreover, there was compelling international evidence that it was the right approach. What was needed now, she believed, was to focus on building a community-focused mental health system capable of meeting the needs of New Zealanders. “This wasn’t about building hospitals to put people in and lock the door any more. This was about mental health being a forgotten area of health for over a century, which was in much need of increased resourcing to turn things around. People needed to understand that this would take time, but we were working as fast as we could.”

The 1980s: deinstitutionalisation peaks

Like many other countries, New Zealand had been steadily dismantling its traditional mental health care system since the 1950s. It was a system built around some unyielding cornerstones: institutional care, state provision and the belief that most people with mental illnesses were incurable. But, around the middle of the century, these orthodoxies were challenged by new ideas about mental illness, new therapies and compelling epidemiological evidence of their effectiveness. Victorian-era asylums like Seacliff and Carrington began shedding patients in droves, and deinstitutionalisation was underway.

¹ Sandra Coney, ‘New Zealand investigates mental health services,’ *Lancet*, 16 Dec 1995, p1620

² *Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (also known as the Psychiatric Report or Mason I Report), Wellington: 1988, pp 181-190

³ Janice Wilson, interview with author 10 November 2008. Unless stated otherwise, all comments are from this interview.

The prime movers behind deinstitutionalisation were clinicians and, increasingly, mental health patients themselves. They shared a belief that people with mental illness were best treated in smaller, more home-like settings where there was dignity, respect and an emphasis of rehabilitation; they advocated the shortest possible period of hospital care, backed up by ongoing community-based treatment and services. Health administrators, too, were increasingly captivated by the arguments for closing the old institutions. Mental hospitals were costly to run and, despite warnings by clinicians to the contrary, community care was perceived as a cheaper option.

Yet at a national level, deinstitutionalisation proceeded in a vacuum. Before the early 1990s, it was never explicitly articulated as national policy; there was no formal strategy, framework or dedicated agency to guide or monitor it. Looking back at the 1980s from 2008, a senior Ministry of Health analyst said, “There was a philosophy. But not necessarily a plan.”⁴

By the 1980s, the proportion of the population in mental institutions had dropped to 225 per 100,000 from an all-time high of 500 patients per 100,000 people in the late 1940s. The actual number of mental hospital patients had also fallen significantly from more than 10,000 in 1965 to around 6,000.⁵ (See Figure A) New Zealand still had sixteen psychiatric and psychopaedic (intellectual disability) hospitals, but most were significantly reducing their in-patient population and some were in the process of closing. The dominance of the large institution as the preferred solution for treating mental illness and intellectual disability was coming to an end.

But the falling number of mental patients in hospital did not indicate an improvement in the country’s mental health (there was no national budget for mental health promotion or education), nor that the mentally ill were being more successfully treated. In fact, the number of first admissions was remaining relatively static, while readmissions were increasing sharply (from 2,500 annually in the early 1960s to 7,739 in 1982.)⁶ A “revolving door syndrome” was developing, whereby many of the same patients simply moved back and forth between hospital and the community.⁷

Nor did fewer patients mean better conditions in mental hospitals. Many older institutions became increasingly dilapidated as budgets were cut. When a particular ward or institution was closed, the perennial problems of over-crowding and staff shortages simply shifted elsewhere. The patients left behind were generally the most dependent and “difficult”, with needs that were complex and costly. A 1986 Department of Health review found fault with psychiatric hospitals for “over-reliance on drug therapies, overuse of seclusion and restraint, ‘Dickensian’ facilities for seclusion, staff shortages, underuse of psychotherapies [and] patients who would not be in hospital if assessment, rehabilitation and community supports were in adequate supply.”⁸

⁴ Andrew Crisp, interview with author 30 November 2008. All comments are from this interview.

⁵ The actual number of people in hospital, as opposed to the rate of institutionalisation, continued growing until the mid-sixties because of population increase: it reached its peak of 10,492 in 1965. For a discussion, see Hilary Haines and Max Abbott, ‘Deinstitutionalisation and Social Policy in New Zealand,’ *Community Mental Health in New Zealand*, Vol 1 No 2, Feb 1985, p46

⁶ *ibid*

⁷ Brent Hall, ‘Innovation and Mental Health Care Policy’ in *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, eds Hilary Haines & Max Abbott, Auckland: Mental Health Foundation, 1986, p74

⁸ Preface, *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, Haines & Abbott, 1986, p vi.⁹ Hall, *op cit*, p77

As this last observation suggests, the decline in the mental hospital population did not correspond with a growth in community-based therapeutic, welfare, housing and rehabilitation services. Various out-patient services were tacked onto hospitals or provided by community organisations, but they were few and inadequately resourced. There was insufficient “sheltered” accommodation for former hospital patients not yet able to live independently. Visiting academic Brent Hall, who addressed the 1985 Mental Health Foundation conference, warned New Zealand to avoid making the same mistakes as the United States, where deinstitutionalisation had led to ex-psychiatric patients becoming “part of a growing homeless population within a hostile society.”⁹

But deinstitutionalisation had gained an irreversible momentum. As Dr Basil James, Director of Mental Health from 1981 to 1990, later recalled, “we had been so busy concentrating on the concept of deinstitutionalisation that we had neglected the community care which must accompany it if it is to work.”¹⁰

Funding and the health reforms

Mental health spending had never been a high priority for New Zealand governments; as historians have noted, “early politicians knew that few votes were won or lost on mental health issues.”¹¹ Typically, less than 8 percent of public expenditure on health went to mental hospitals, with negligible other spending on mental health. This low level of funding remained a major barrier to establishing community services in the deinstitutionalised era.

So did the arrangements for purchasing services. In 1972, central government had relinquished much of its control over mental hospitals to the country’s locally elected hospital boards. The boards became responsible for deciding how public funds should be spent to meet the needs of local people. The switch to population-based funding caused particular problems in regions such as Otago, where the population was static or declining. There were wide variations in the nature and quality of mental health services across the country.

Accounting procedures meant it was unclear what percentage of its total budget a hospital board might be spending specifically on mental health and, of that, how much was allocated to non-hospital mental health services. “From the data available,” commented Mental Health Foundation chair Max Abbott, “it seems that mental health almost invariably receives a disproportionately small slice of the fiscal cake.”¹² The reasons included both a lack of lobbying power by the mental health sector, and the boards’ preference for funding more fixable and “glamorous” health problems. As Andrew Crisp, a senior policy analyst at the Ministry of Health, recalled in 2008: “When places like Oakley and Carrington were closed,¹³ there was little transparency about what happened to the funding that ran them. Not all the money was applied to replacement mental health services.”

⁹ Hall, op cit, p77

¹⁰ Quoted in Brunton, ‘Out of the Shadows’, in *Past Judgement: Social Policy in New Zealand History*, eds Bronwyn Dalley & Margaret Tennant, Oxford University Press, Dunedin, 2004, p88

¹¹ *ibid*, p78

¹² Preface, *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, Haines & Abbott, 1986 , p viii

¹³ These large Victorian-era psychiatric hospitals in Auckland merged in 1987 and closed in 1993.

Some extra funding for mental health was made available periodically. – for example, the Government allocated some of the proceeds from the privatisation of Telecom to mental health. Earlier, an injection of money from the 1977 Budget-night “beer and baccy” tax allowed community mental health services to be established under the umbrella of hospital boards. Some worthwhile services were set up as a result, notably community mental health centres in Auckland run by Carrington Hospital and the Auckland Hospital Board. But the funding arrangement was uncertain, and the money could be accessed only at the discretion of administrators within the hospital boards.¹⁴ Non-governmental organisations trying to establish services were completely reliant on fund-raising: in 1977, the newly-formed Mental Health Foundation managed to raise \$2 million for mental health promotion through a national Telethon. In a country of three million people, it was a massive show of support for a fledgling organisation “independent of government funds and willing to initiate projects which could well transform the whole face of the caring services in the New Zealand community.”¹⁵

However, with the attitudes and funding choices of hospital boards still heavily orientated towards state-run institutions, “community care was largely funded with the crumbs from the institutional table.”¹⁶ Dr Fraser McDonald, iconoclast superintendent of Carrington Hospital and a prime mover behind the Auckland community health centres, expressed his frustration with the situation in his region:

“Even I, supposedly dictator of all I survey, of the biggest mental hospital complex in New Zealand, with a devoted staff and administrative staff who want to follow along these [pro-community care] lines, still have to spend 86 percent of my budget on that terrible, great big bloody hotel that I run up there ... and only 14 percent on the vast, hugely increasing number of psychiatric patients who are out there in the community. Even I haven’t been able to change ... the inertia, so let us not underestimate the difficulties.”¹⁷

The sweeping public sector reforms of the late 1980s and early 1990s brought to the whole health sector a competitive market structure, in which the purchasing and provision of services were separated. First, the hospital boards were transformed into Area Health Boards. Then, in 1993, their purchasing functions were taken over by four new Regional Health Authorities (RHAs), while their service provision arms were refashioned into 23 Crown Health Enterprises (CHEs). Later, the RHAs were combined into a single purchasing agency, the Health Funding Authority (HFA).¹⁸

The health reforms came as part of a wave of managerialist thinking. Whereas mental hospitals had traditionally been the fiefdoms of powerful medical superintendents, supported by a chief nurse and an accountant, hospital managers now had the power to determine where money was spent. Recalled Dr David Chaplow, former head of New Zealand’s largest forensic psychiatric

¹⁴ Hall, op cit, p75

¹⁵ *Evening Post*, 25 February 1977, quoted in Mental Health Foundation, *Change in Mind: A history of the Mental Health Foundation of NZ*, Auckland, 2008, p20

¹⁶ From a letter by the Minister of Health to a Mrs M. Gilbert, 3 May 1985, quoted in Brunton, ‘Out of the Shadows,’ Dalley & Tennant, p88

¹⁷ Transcript of panel discussion in *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, Haines & Abbott, 1986, p14

¹⁸ In 2000, the funder/provider split would be reversed with the formation of 21 District Health Boards, all with combined purchasing and service functions.

service, the Mason Clinic, and the Ministry of Health's Director of Mental Health since 2001; "We had probably two or three years of the management model ... It was really a competitive business model: the hospital was a business, and it was going to make money."¹⁹

The greater fiscal austerity ushered in by the health reforms had a significant impact on mental health, accelerating the movement of patients out of hospitals and constraining the establishment of alternative community-based services. Many commentators have noted that when health budgets were under pressure, psychiatric services were often the first to be cut. Given the public stigma still associated with mental illness and an absence of well-resourced lobby groups, hospital managers rarely met opposition. As a Public Service Association field officer said at the time: "Although community care had begun with the best interests of patients in mind, it had been seized upon by the non-medical administrators as a means of reducing expenditure."²⁰

As a result, community-based mental health services in the 1990s — whether providing treatment, training, accommodation, prevention or other forms of help — remained patchy or non-existent in most parts of the country. For example, after the closure of Cherry Farm (a mental hospital near Dunedin) in 1992, 540 "clients" were discharged into the community. Most were former long-stay patients with intellectual disabilities. There were 18 community-based mental health staff to support them and fewer than 30 supervised or licensed homes to accommodate them.²¹ The situation was not atypical, as Max Abbott had earlier told the Mental Health Foundation conference:

"Nowhere in New Zealand is there adequate provision of community services and supports, even though some hospital board areas have greatly reduced their psychiatric hospital populations. Some of the smaller boards in fact have no mental health services of any description. One of the problems has been that money has not followed, let alone preceded, patients into the community. Voluntary organisations that attempt to meet some of the needs of ex-patients living in the community lack a secure funding base."²²

However, he cautioned that more funding alone would not bring about the kind of comprehensive community-based mental health system that was needed. "There is a need for national direction in the form of an overall philosophy and the specification of service guidelines and minimum standards of care,"²³ Dr Abbott said.

Filling the policy void

But a sense of national direction was slow to develop, as Janice Wilson found when she became Director of Mental Health. "There was no over-arching national policy. Even though what was called deinstitutionalisation had been occurring for some years and had been pushed by strong leaders in the mental health system — not just here, but internationally — New Zealand had not

¹⁹ Dr David Chaplow, interview with author 19 Nov 2008. Unless stated otherwise, all comments are from this interview.

²⁰ *Otago Daily Times*, 3 June 1982. Quoted in 'Unfortunate Folk': *Essays on Mental Health Treatment*, eds Barbara Brookes and Jane Thomson, University of Otago Press, Dunedin, 2001, p177

²¹ *ibid*, p182

²² Preface, *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, Haines & Abbott, 1986, p vii-viii

²³ *ibid*.

put together any kind of national strategy around the development of community mental health services.”

Apart from a general mental health policy statement published in 1969, guidelines, procedures and protocols were either absent or inadequate. For 20 years, departmental staff and service providers seeking guidance on operational policy relied on the Mental Health Division’s staff rule book (1971) and an assortment of head office circulars. Despite the efforts of Dr Basil James as Director of Mental Health (1981-1990) to prioritise policy development, “policy unfolded less as a centrally driven, rational and overarching plan, than as a hastily conceived, poorly managed (and local) undertaking.”²⁴ Nor was it helped by the state sector reforms and restructuring which, it has been said, “no rational and departmentally manipulated policy-making process could have withstood.”²⁵

The Department’s work had also been fragmented. Mental health policy and the statutory aspects of mental health were dealt with in separate areas of the Department, until a small mental health unit was established in December 1986. Other government departments (Social Welfare, Housing) handled important related areas, such as benefits, housing support and vocational training for the mentally ill or disabled. As a consequence, commented David Chaplow, “mental health never had a place at the table. It was never an entity in itself.”

One significant achievement had been the review of the 1969 Mental Health Act, which began during Basil James’ term. It involved not only the Department, clinicians and health administrators, but also the legal profession and the emerging mental health consumer movement. Reflecting changing social thinking about individual rights and freedoms, they advocated greater patient rights in areas like committals, the use of force and seclusion. The review took ten years, culminating with the passing of the 1992 Mental Health Act. Key features of the new legislation included a narrower definition of “mental disorder” that excluded certain categories of people from being committed for compulsory treatment; provision for people to be compulsorily assessed and treated in the community rather than in hospital only; stronger appeal provisions; and formal recognition of the importance of cultural factors in diagnosis and treatment. The official approach now was that the mentally ill should be treated in the least restrictive environment.²⁶

The new law, and the thinking behind it, shaped the policy environment which Janice Wilson entered in 1993. The Department was by now the Ministry of Health and retained a dedicated (albeit small) Directorate of Mental Health, enabling a more cohesive and purposeful approach to mental health policy. But Janice Wilson recognised that the main focus of policy development was still deinstitutionalisation — a process which, by this time, was all but over. Thus, the Ministry was engaged in catch-up policy-making, when Wilson believed it should be moving forward:

“Just after I came, I can remember going to a Cabinet committee where Prime Minister Jim Bolger turned up. At that time, discussion about deinstitutionalisation tended to come from a disability perspective. But I said; this is really about the adequacy of mental health service delivery. It’s about

²⁴ Warwick Brunton, ‘Mental health: the case of deinstitutionalisation,’ in *Health and public policy in New Zealand*, eds Peter Davis and Toni Ashton, Auckland, Oxford University Press, 2001, pp187-192

²⁵ *ibid*

²⁶ Office of the Director of Mental Health, *Annual Report 2005*, Wellington: Ministry of Health, p30

how to deliver services that meet the needs of individuals in the best possible way; it's not just about closing hospitals.”

Recalled long-serving Ministry of Health policy advisor Linda Jacobs, “Politically, the genius of Janice’s leadership at that time lay in turning the debate around, in moving it away from deinstitutionalisation and towards the need to build community services.”²⁷

The first national strategic direction for mental health was published in 1994, under Janice Wilson’s leadership. *Looking Forward* described the services and approaches needed in the post-deinstitutionalisation era. It was a landmark document, setting the course for the development of the mental health system over the next decade and articulating key underlying principles for the first time. It said community-based services were “the best and ... most cost-effective” and “the linchpin for the mental health system”. It called for greater involvement by Māori in planning and delivering services (Māori had higher rates of psychiatric treatment than other populations, and were generally more ill by the time they received help), and more responsiveness to the needs of all service users. To reduce the prevalence of mental illness in New Zealand, *Looking Forward* emphasised the importance of prevention measures, and strategies to diminish stigma and stereotyping. It talked about the need for workforce development so that there were sufficient people with the right skills to deliver community-based mental health services.

Another important innovation was the setting of an access target. *Looking Forward* said the immediate priority must be to provide services to help the 3 percent of adult New Zealanders and 5 percent of children/young people who epidemiological evidence showed were experiencing severe mental disorders at any one time.²⁸ It was expected that the primary health sector would cater for people with less severe needs, and *Looking Forward* focused on meeting the needs of the 3 percent. Reaching these targets depended on the purchasing decisions made by the RHAs (and later the HFA). *Looking Forward* charged them with purchasing more and better services, including those targeted at Māori and at children and young people.

The national strategy reflected the decentralised philosophy of the time. While the Ministry of Health was the main policy advisor on mental health and had oversight of the system, responsibility for policy implementation and service planning lay with the funding agencies. Nor was the Ministry fully responsible for monitoring: the recently-established Crown Company Monitoring and Audit Unit (CCMAU) was charged with monitoring the performance of the Crown Health Enterprises (CHEs). Recalled Janice Wilson,

“When the mental health strategy was launched, there was tremendous call from stakeholders and to some extent from the public for a national action plan. But that was resisted by the Centre; it wasn’t the Centre’s role to do that... That was the kind of political policy era we were in.”

She was uneasy about this approach. Making the transition to the kind of community service environment that *Looking Forward* envisaged, especially when there were still conflicting views about the merits of deinstitutionalisation, would require strong direction from the Centre. “I started advocating within the Ministry for us to be more active around planning. There was quite

²⁷ Interview with author, 30 November 2008

²⁸ These figures were based on international studies, particularly the ‘Tolkien’ Report from New South Wales. The access target for children and young people was not arrived at until the publication of *Looking Forward*’s companion plan, *Moving Forward*, in 1997.

a lot of tension about how people saw the role of the Centre. And then of course subsequent events saw a reversal of the ‘hands-off’ stance.”

Those events took the form of a succession of high-profile mental health scandals, culminating in the release of the damning Mason Report. Within two years of the report, the sector had both a national action plan and a detailed blueprint for services.

Scandals and crises

Beyond the Ministry of Health, the state of the mental health system was also receiving wide attention in the early 1990s, but for all the wrong reasons. In 1993, psychiatric nurse Neil Pugmire captured headlines when he was censured after “blowing the whistle” on the impending release of a child sex offender from Lake Alice Psychiatric Hospital; a year later, the offender was arrested for assaulting a boy with intent to commit sexual violation.²⁹ In 1994, retired judge Ken Mason, leading an inquiry into the death of a young man while police were trying to have him admitted to a psychiatric hospital, described the mental health system as operating at a “number 8 fencing wire level.”³⁰ A year later, two mental health patients — one cared for by a community-based forensic service, the other an outpatient — were shot dead by police within a three month period, both in incidents involving firearms.

Some members of the public called for a return to the days when the mentally ill were held under lock and key. Others said the succession of crises pointed to a lack of community capacity and will to care for some of its most vulnerable members. In 1995, amidst a media frenzy and ongoing attacks in Parliament, Health Minister Jenny Shipley announced a ministerial inquiry into the state of the mental health system, again appointing Ken Mason to lead a three-person inquiry team.

The 1996 Mason Inquiry tapped into a deep seam of professional and community concern about mental health. The original deadline for submissions was extended; instead of the expected 200 written submissions, 720 were received.³¹ They came from clinicians, professional organisations, non-governmental agencies, local government, Māori service providers and advocates, and also from individual users of mental health services, their families and supporters. The Mason Report included many personal accounts of the system — stories of neglect, despair and frustration as mentally ill people and their families tried to cope in the face of under-funded, uncoordinated services and inadequate support. The difficulty of getting seriously disturbed people committed to hospital under the 1992 Mental Health Act was a constant refrain, as was the drastic reduction of in-patient beds without a corresponding increase in community services.

The report said that while the mental health budget had grown by nearly 6 percent per annum between 1990 and 1996 (to \$390 million), this was patently insufficient. Best evidence showed that current services were available to less than 2 percent of the population. It concluded:

²⁹ Released from jail in 2001, and living under a new name, the offender was eventually sentenced to preventive detention in 2003 after sexually assaulting three boys and kidnapping another.

³⁰ *Dominion Post*, 2 October 1995. “Number 8 wire” is a commonly-used phrase in New Zealand, referring to the use of ingenuity and basic materials to fix a problem – a characteristically ‘Kiwi’ approach.

³¹ *The Press*, 10 June 1996, p19

“Mental health services are in disarray... The recent increases in funding ... are but an inadequate ‘catchup’ to compensate for centuries of financial neglect... New Zealand must wake up to the fact that, for decades, mental health services have been delivered ‘on the cheap’. This has resulted in the gradual disintegration of systems, a flight of expertise, a loss of morale by those who remain within the system and a potential loss of confidence by the community. Mental health must not be at the end of the pecking order when funding for general health services is being decided. It must be regarded as a prestigious service if only because, in one form or another, 30 percent of New Zealanders will access the service [at some point in their lives].”³²

The Mason Report made only a handful of broad, but potentially significant, recommendations. Chief among them were:

- increase mental health funding by an extra \$125-\$140 million per annum over the next five years, taking the total public spend from \$390 million in 1995/96 to \$515-\$530 million in 2000/01.³³ This would be sufficient to run “a comprehensive, integrated mental health system for all age groups that could achieve a 3 percent per annum population cover.”³⁴ Extra money again would be needed for workforce development; education, promotion and prevention; and primary mental health care.
- “ring-fence” funding at both RHA and CHE levels
- establish an independent watchdog, the Mental Health Commission, to oversee the system, monitor the implementation of the national mental health strategy, undertake public education, and develop a national blueprint for services.

Responding to the Mason Report

Government moved swiftly to implement the report’s recommendations. Staffing in the Ministry’s mental health group was doubled, and it was announced that core funding would increase by \$142.2 million over the next five years.³⁵ In 1997, the Ministry released its national action plan, *Moving Forward*, the companion document to *Looking Forward*. The Mental Health Commission began work (although not with such a broad role as the Mason Inquiry had envisaged), becoming a Crown entity in 1998. The same year, the Commission released the *Blueprint for Mental Health Services: How Things Need to Be*, detailing what services were needed to match the goals set out in *Looking Forward/Moving Forward*. The access targets were refined to reflect available data, although the “3 percent” remained the priority group. A specific target for Māori was set: mental health services needed to reach 6 percent of the Māori population. The needs of other specific population groups (such as children and young people, the elderly) and disorders (addictions, personality disorders etc) were identified.

The *Blueprint* said its targets could be achieved within ten years, assuming that the Government continued to provide the substantial new funding recommended in the Mason Report. This extra funding, soon known as ‘Blueprint funding’ was initially outside the core Vote: Health budget, but was subsequently incorporated into it. The stream of Blueprint funding, subject to Ministry request every three years, continued uninterrupted from 2000 to 2008.

³² Ministerial inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services (the ‘Mason Report’), Wellington: May 1996, p169

³³ See Figure B for the actual funding increase over the period.

³⁴ *ibid*, p172

³⁵ Minister of Health, ‘Government Acts on Mental Health Inquiry Recommendations,’ press release, 27 June 1996

The impact of the ongoing funding injection was significant. Between 1995/96 and 2004/05, public funding for mental health services grew from \$390 million to \$866.6 million; taking inflation into account, it increased by around 88 percent (*see Figure B*).

On the ground, health boards used Blueprint funds to establish new services and expand existing ones, especially in regions experiencing rapid population growth.³⁶ Service providers included DHBs themselves, NGOs and private providers. Nationally, Blueprint funding was spent on the highly successful public education programme, *Like Minds Like Mine*, as well as the purchase of new drugs, research, workforce development and running the Mental Health Commission.

As demanded by the Mason Inquiry, mental health funding was also ring-fenced so it could not be diverted to other areas of spending by providers — first the CHEs and then the 21 District Health Boards (DHBs), which replaced them in 2000. Janice Wilson described the benefits of ring-fencing as multiple: as well as providing funding security, ring-fencing “has had an emotional importance to some extent, so people can see that government has been very serious about this priority and wants to see growth.”

For those in the “firing line” at the Ministry, what was the impact of the Mason Report? Janice Wilson accepted the fact that, in the eyes of the public, her position made her directly responsible for the shortcomings highlighted in the report. “I was often in the media at that time, and it was very pressured. I wanted to show that I was empathetic to the plight of victims, and understood the awful things they had been through.” She also accepted the Mason Inquiry’s findings about an absence of leadership, but believed that this was a consequence of the “hands-off” philosophy that had been taken to planning and monitoring. In the three years she had been at the Ministry, Janice Wilson had challenged this approach, arguing that “when you are bringing about major policy reform like this, particularly starting from a low base and in an environment where there are many conflicting views, you do need consistent national leadership. So it was quite correct of the Mason Inquiry to tackle the leadership issue.”

But as well as acknowledging the failings of the past, she wanted to communicate a vision for the future. And, in that sense, the publication of the Mason Report — bruising though it may have been for her and the Ministry — proved useful. It helped push mental health higher on the political agenda than it had ever been before. Moreover, its findings powerfully reinforced the direction Janice Wilson had been advocating ever since she arrived at the Ministry three years earlier. Deinstitutionalisation had happened, driven by largely laudable motives but without adequate resources and policies to support it. The consequences were starkly apparent on nearly every page of the Mason Report. What mattered now was developing a mental health system to replace the flawed system of the past.

³⁶ Mental Health Commission, *Te Haererenga mo te Whakaōranga*, 2007, p15

Appendix A:

From asylums to community care: a short history of deinstitutionalisation

In nineteenth century Europe, compulsory incarceration in a lunatic asylum was the standard response to mental illness, and the model was duplicated in colonial New Zealand. By 1876 — not quite fifty years after New Zealand became a British colony³⁷ — there were already eight lunatic asylums across the country, housing 748 inmates (a rate of 193 inmates per 100,000 people).³⁸ In that year, administrative responsibility for the asylums transferred from the former provincial governments to central government, and an Inspector-General of Asylums was appointed. Commenting in 1894 on the rapidly-increasing asylum population, Inspector-General Duncan McGregor lamented “[the] strong tendency to throw every case that can be brought within the definition off the local rates on to the general taxation of the colony.”³⁹

Led by often autocratic medical superintendents, the lunatic asylums were administered separately from the rest of the healthcare system. This reinforced their geographical isolation, and the mix of fear and horror with which they were generally seen by the public. Patients comprised not only people with mental illnesses but also the intellectually handicapped, the elderly, epileptics, alcoholics and the socially isolated. Little treatment was offered. Work, exercise and wholesome food were usually all that could be offered; unmanageable patients were put in restraining garments or secluded. The safekeeping of lunatics, not cure, was the primary role of the asylum.

The asylum population grew steadily into the twentieth century. Over-crowding became rife as the old institutions were stretched beyond capacity and staff shortages became acute. After 1900, the number of beds considered acceptable in such institutions grew from 500 to 1,000.⁴⁰ Some new facilities were built, increasingly along villa-style lines, but a lack of funding and a perennial shortage of trained staff meant there were never enough beds to meet demand.

Meanwhile, there was a marked shift from custodial care to more active treatment of the mentally ill. The use of drugs — bromide, morphine, chloroform, luminal sodium for epileptics — became widespread, although results varied. Influenced by the treatment of ‘shell-shocked’ soldiers, hypnosis and psychotherapy become more common after World War One. Occupational therapy was introduced in the 1930s. New physical therapies were tried: injections of malarial serum, insulin coma injections, cardozol shock treatment, electric narcosis and electro-convulsive (ECT) therapy. In 1945, the first New Zealand pre-frontal leucotomy was performed, and considered a suitable treatment for schizophrenics.⁴¹

The administration of the mental health system changed only gradually over the first half of the century. In 1907, the government established a Mental Hospital Department (the term was by then considered to have more desirably scientific connotations than “asylum”, just as “mental

³⁷ New Zealand became a British colony on 6 February 1840 when more than 500 Māori chiefs and representatives of Queen Victoria signed the Treaty of Waitangi, now regarded as the nation’s founding document.

³⁸ Haines & Abbott, ‘Deinstitutionalisation and Social Policy in New Zealand,’ in *Community Mental Health in New Zealand*, 1985, p45

³⁹ Quoted Cheryl Caldwell, ‘Truby King & Seacliff Asylum 1889-1907’ in Brookes & Thomson, p38

⁴⁰ Warwick Brunton, ‘Out of the Shadows’, in Dalley & Tennant, p82

⁴¹ Haines & Abbott, ‘Deinstitutionalisation and Social Policy in New Zealand,’ in *Community Mental Health in New Zealand*, 1985, p50. See also Brookes & Thomson, pp144-150.

defective” became favoured over “lunatic.”)⁴² The Department had its own minister but was still separate from the rest of the health system. Apart from running psychiatric institutions, it was responsible for registering mental nurses; an occupation that had hitherto been little different from that of a prison warder began to be professionalised.

The treatment of the mentally ill began to broaden a little. In 1911, recognising that acute illness might be prevented by earlier treatment, voluntary admission to mental hospitals became possible. From 1925, psychiatric outpatient clinics were established at some general hospitals, allowing people to seek treatment for milder conditions without the stigma and abysmal conditions associated with traditional mental hospitals. In 1936, Wellington’s public hospital became the first in the country to open a psychiatric ward, again with a view to earlier intervention.⁴³

Though these changes were piecemeal and reflected the efforts of individual clinicians more than planned policy, they were nonetheless significant. The tide of medical and public opinion was turning against asylums, treatment was increasingly seen as preferable to detention, attempts were underway to “humanise” aspects of the hospital environment, and some services were available beyond hospital walls. However, many fundamentals remained unchanged. The standalone institution was still the linchpin of the system and consumed the majority of the mental health budget. The rate of institutionalisation reached its peak in the late 1940s, with nearly 500 patients per 100,000 people (equating to around 8,000 patients).⁴⁴ Many of these patients continued to be seen as hopeless cases: in 1945, of the 8,829 mental hospital patients, 60 percent were officially deemed incurable.⁴⁵

The development of a new generation of psychotropic drugs in the early 1950s changed everything. Drugs such as thiorazine were found to rapidly modify the symptoms of many mental disorders; moreover, they could be administered outside hospitals.⁴⁶ In combination with physical therapies such as ECT, and greater interest in psychotherapies, the new drugs accelerated the trend to shorter hospital stays, often followed-up by treatment in outpatient clinics. Further, as Hilary Haines and Max Abbott have noted, “the efficacy of drug and other treatments attracted publicity and meant that more people sought help from psychiatric hospitals.”⁴⁷

Long-term patients began to be moved out of institutions. A few went to “halfway houses” or supervised hostels, but these were in short supply: even by 1970, while there were 8,072 inpatient psychiatric beds, only 148 beds were available in community accommodation.⁴⁸ Most former patients were discharged to the care of family members or simply left to their own devices. Hospital stays became progressively shorter; more people were now being admitted for

⁴² Warwick Brunton, ‘Out of the Shadows’, in Dalley & Tennant, p80

⁴³ Susan Fennell, ‘Psychiatry in New Zealand 1912-1938,’ in Brookes & Thomson, p148

⁴⁴ Haines & Abbott, ‘Deinstitutionalisation and Social Policy in New Zealand,’ in *Community Mental Health in New Zealand New Zealand*, 1985, p45

⁴⁵ Warwick Brunton, ‘Deinstitutionalisation: A Romance for All Seasons,’ in *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, Haines & Abbott, 1986, p48

⁴⁶ Haines & Abbott, ‘Deinstitutionalisation and Social Policy in New Zealand,’ *Community Mental Health in New Zealand*, 1985, p49

⁴⁷ *ibid*, pp 47-48

⁴⁸ Department of Health statistics, reported in Warwick Brunton, ‘Mental health: the case of deinstitutionalisation,’ in Davis & Ashton, p189

short periods of acute care. In 1961, 12 percent of patients had been in hospital for less than a year; twenty years later, 31 percent of patients were in this situation.⁴⁹

As approaches to treatment changed, profound shifts took place in other areas of the decades-old mental health system too. The Mental Health Act of 1969 provided a new definition of mental disorder based on diagnostic features, scrapped outmoded terminology, and clarified distinctions between mental illness and intellectual disability. Responding to calls by clinicians and pressure groups, differentiated services began emerging for specific groups — hostels and training for the intellectually disabled, specialised geriatric services and subsidised rest home care for the elderly who were otherwise often “dumped” in psychiatric institutions.⁵⁰ Throughout the sixties, hostels and group homes for former long-term mental patients were established in the community by the voluntary sector and hospitals. A domiciliary psychiatric nursing service began, allowing medication to be administered in patients’ own homes.

By 1970, the rate of people in mental institutions had already fallen from its 1940s peak to around 360 patients per 100,000 people, and was dropping steadily. In 1973, the government announced a moratorium on the provision of new beds in psychiatric hospitals. A further blow to the status of the large institutions came a year later, when a national survey of residents in psychiatric and psychopaedic hospitals recommended that slightly under half the mentally subnormal patients and around a quarter of psychiatric patients need not be there.⁵¹ While accompanying advice that “resources for facilities and support staff must precede patient discharges”⁵² was largely overlooked, the survey’s main finding was embraced enthusiastically. It reinforced many clinicians’ belief that institutional care was not only ineffective, but also self-perpetuating; it also lent weight to the arguments of those who opposed mental hospitals (especially practices such as committal and compulsory treatment) on human rights grounds. The results of the survey had additional appeal to administrators responsible for the mounting costs of staffing, running and maintaining large institutions. A Dunedin newspaper reported in 1971 that while it cost \$70 a week to care for a psychiatric patient in a mental hospital, it cost only \$16 a week to maintain them in the community “providing family or friends could accommodate them.”⁵³

The combined impact of clinical developments, new thinking about mental illness and a desire to make cost savings was profound. Well before it was articulated as national policy in the 1990s deinstitutionalisation — in the sense of discharging residents from mental hospitals — had become a reality.

⁴⁹ Haines and Abbott, ‘Deinstitutionalisation and Social Policy in New Zealand,’ *Community Mental Health in New Zealand*, 1985, p47

⁵⁰ Warwick Brunton, ‘Deinstitutionalisation: A Romance for All Seasons,’ *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, Haines & Abbott, 1986, p57

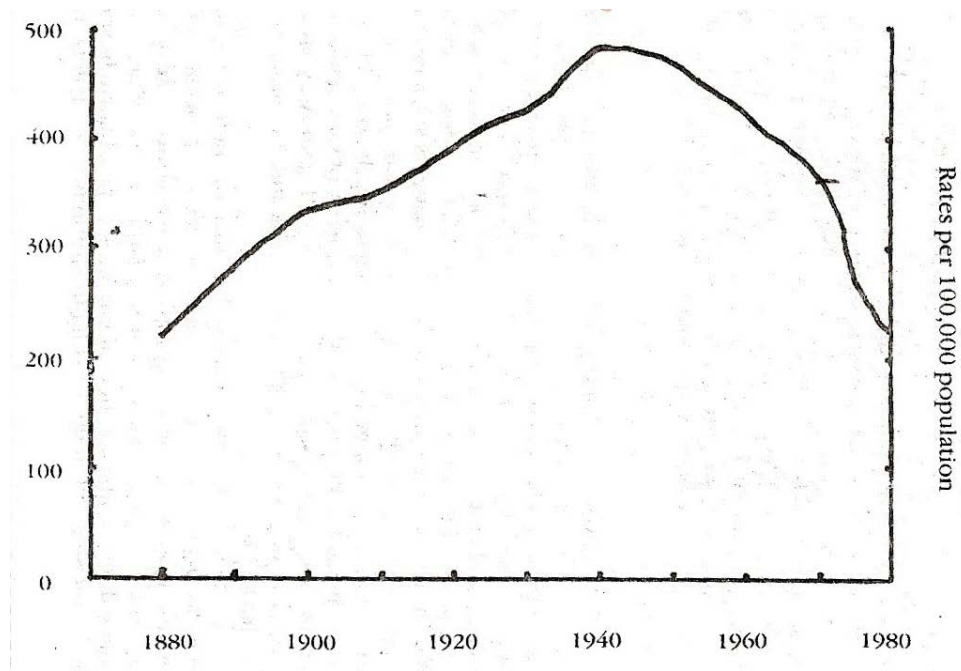
⁵¹ I.J Jeffery & J.M. Booth, ‘Survey of Patients in Psychiatric Hospitals,’ 1974, quoted in *The Future of Mental Health Services in New Zealand: Deinstitutionalisation*, Haines & Abbott, 1986, p 63

⁵² Warwick Brunton, ‘Mental health: the case of deinstitutionalisation,’ in Davis & Ashton, p187

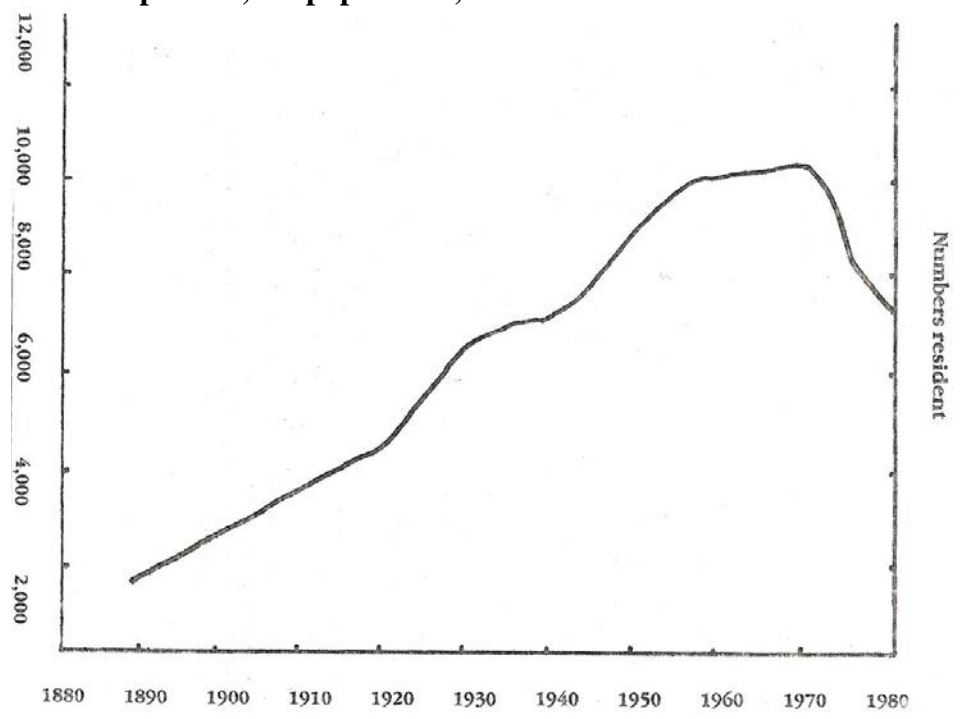
⁵³ *Evening Star* 12 August 1971. Quoted in Jeff Kavanagh, ‘Cherry Farm 1952-1992’ in Brookes & Thomson, p175

FIGURE A:

(a) New Zealand's psychiatric hospital population: average number of residents – rates per 100,000 population, 1876-1982



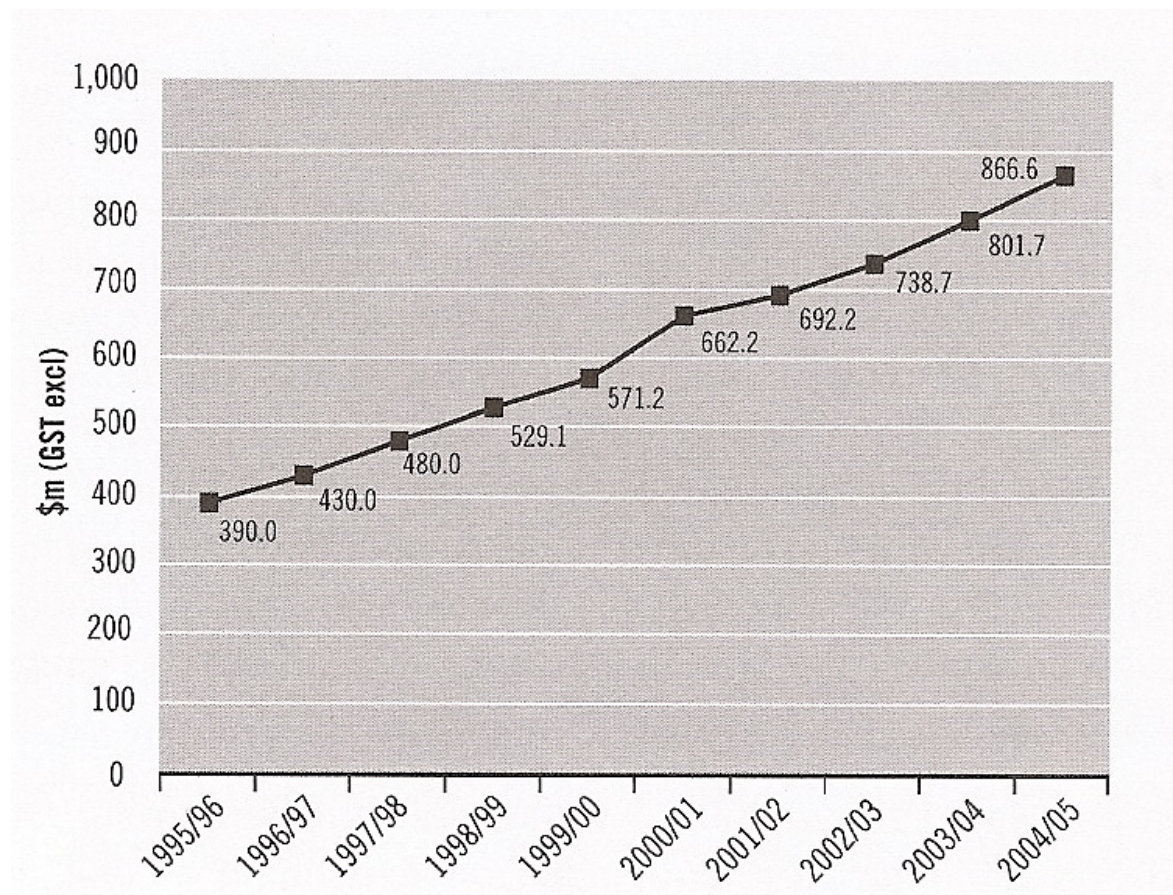
(b) New Zealand's psychiatric hospital population: average number of residents – absolute numbers per 100,000 population, 1876-1982



Source: Hilary Haines & Max Abbott, 'Deinstitutionalisation and Social Policy in New Zealand,' *Community Mental Health in New Zealand*, Vol 1 No 2, February 1985, pp54-55. Based on National Health Statistics Centre, Mental Health Data, Department of Health, 1982

FIGURE B:

Public funding for mental health services, 1995/96 to 2004/05



Source: Mental Health Commission, *Te Haerenga mo te Whakaōranga: The Journey of Recovery for the New Zealand Mental Health Sector*, Wellington: 2007, p14. Data source: Ministry of Health.